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THE WEST VIRGINIA

Medical Journal

OFFICIAL ORGAN OF THE WEST VIRGINIA STATE MEDICAL ASSOCIATION

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VOL. 58, NO. 1 JANUARY, 1962

95th Annual Meeting, The Greenbrier, August 23-25, 1962

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68961

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JANUARY
1962

Vol. 58 No. 1

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Assaciatian

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.

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The West Virginia Medical Journal

January, 1962 Vol. 58, No. 1

Combined Intrauterine and Extrauterine Pregnancy*

(Case Report)

Robert E. Gibson, M. D., and Geza Z. Gaal, M. D.

The coexistence of intrauterine and extrauterine pregnancy first was designated as "combined" pregnancy in 1876, by Parry[1], who stated that of 500 cases of tubal pregnancy collected by him, 22 were complicated by coexistent intrauterine gestation.

Strauss[2], in 1898, was able to collect 32 cases from the literature and, in 1926, Novak[3] increased the number to 276.

De Voe and Pratt, in 1948, published a comprehensive review on the subject, reporting 395 authentic cases. Reeves and Savarese[4] stated in 1954 that 421 cases of simultaneous intrauterine and extrauterine pregnancy are known to be reported.

Winer, Bergman and Fields[7], in 1957, added 71 cases to the list, thereby increasing to 466 the number of reported cases.

It seems beyond doubt that only a small per cent of the true number of cases has been reported, especially during recent years, also that many times the condition goes undiagnosed, particularly in cases in which the patient is treated in two or more hospitals or by two or more physicians.

Bisca and Felder[8], in 1960, reported one more case, while McFarland and Townsend, a few months ago, reported two cases in Canada. In publishing this paper, our own case is added to the foregoing list with its conclusion.

*From the Department of General Surgery, Herbert J. Thomas Memorial Hospital, South Charleston, W. Va.

Submitted to the Publication Committee, September 2, 1961.

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Recognition of Combined Pregnancy

Although the brief historical review may serve to indicate that combined pregnancy is unusual and its occurrence infrequent, coexistence of intrauterine and extrauterine gestation deserves serious consideration in the differential diagnosis of twins, ectopic pregnancy and abortion, especially in the presence of conflicting signs and symptoms.

According to De Voe, combined pregnancy may be expected in approximately 0.8 per cent of all ectopic pregnancies and in 0.003 per cent of gestations as a whole, leading to the estimate of one combined pregnancy in every 30,000 gestations.[7]

Winer's statistical data revealed that of 71 cases of combined pregnancy, there were 44 in which the extrauterine gestation was terminated first and 16 in which the intrauterine gestation was the first to terminate. In 15 of the 44 combined pregnancy cases just referred to, the second (intrauterine) pregnancy remained undiagnosed. In 25 of the 44 cases with prior termination of the extrauterine pregnancy, the coexistent and surviving intrauterine gestation reached the third trimester.

The case reported in this paper represents a combined pregnancy in which the extrauterine conception was terminated first and the coexisting intrauterine gestation reached full term, with spontaneous delivery on the estimated day of confinement.

Case Report

The patient, a 21-year-old white female, was first seen in the office August 27, 1959, her only complaint being that her menstrual period was approximately one week overdue. Her last period had been July 20, 1959.

After physical and pelvic examination, a tentative diagnosis of early pregnancy was made. A Friedman test was suggested but she preferred to wait and see. On August 29, two days after her office visit, she was admitted to Herbert J. Thomas Memorial Hospital, with complaints of severe, lightning-like pain in the left lower abdominal quadrant. There was no shock nor vaginal bleeding.

Past History. Menarche began at age 13. Menstrual periods occurred every fourth week regularly, lasting 5 to 8 days, with occasional cramps.

The patient had delivered a full term normal infant November 10, 1955, in our hospital. This was the only previous pregnancy and the delivery, as well as the post partum period, was normal. There was no history of any long lasting nor systemic illness, no history of previous surgery, no allergies.

Systemic review was essentially negative and the family history was negative for heredofamilial disease.

Physical Examination.—The patient appeared alert and eager to cooperate. Blood pressure 120/70. Temperature 98.6 F., pulse 88 and respiration 22.

The only positive findings were a soft abdomen with tenderness over the left lower quadrant and a soft, closed cervix, with marked tenderness in the left adnexa on bimanual pelvic palpation.

Initial Laboratory Work.—Blood—Hemoglobin 13.2 Gm.; hematocrit 40 vol. %; WBC 13,700; segmented neutrophils 81%; lymphocytes 18%; monocytes 1%. Blood serology was negative. Blood type: B, Rh. positive. Urinalysis was negative.

Hospital Course.—On the day following admission, August 30, 1959, the pain subsided and there was only some residual tenderness over the left lower abdominal quadrant. Vital signs remained stable.

On the third hospital day, severe, generalized, abdominal pain developed. The pain was aggravated by sitting up and by walking. There was tenderness, with rebound, in both lower quadrants. Repeat CBC showed hemoglobin 12.9 Gm.; hematocrit 39 vol. %; WBC 8,400; segmented neutrophils 62%; lymphocytes 37%; eosinophils 1%.

Vital signs remained stable with, in fact, some improvement noted in blood pressure, taken every 30 minutes, and stabilizing at around 135/80. During the two days' observation, intravenous fluids were given, also Terramycin in adequate dosage.

The initial impression of ectopic pregnancy was retained, the possibility of combined pregnancy was suspected, and appendicitis had to be ruled out.

Operation.—Exploratory laparotomy, which now seemed indicated, was accomplished August 31, 1959.

On opening the peritoneum, there was blood in the abdomen and pelvis. This was suctioned off. Examination of the organs revealed a ruptured tubal pregnancy on the left. The left ovary, right ovary and right tube, grossly, were normal. Enlargement of the uterus was not sufficiently significant to confirm the possibility of combined pregnancy. En bloc removal of the left tube including the mass was carried out. Closure of the abdomen was preceded by incidental appendectomy.

Pathologic Report.—The specimen was described grossly as a sausage-shaped fallopian tube measuring 8 X 5 X 5 cm. The serosa was purple-red, dull, and hemorrhagic. Protruding from the fimbriated end were a purple-red blood clot and spongy tissue. On section the tubal

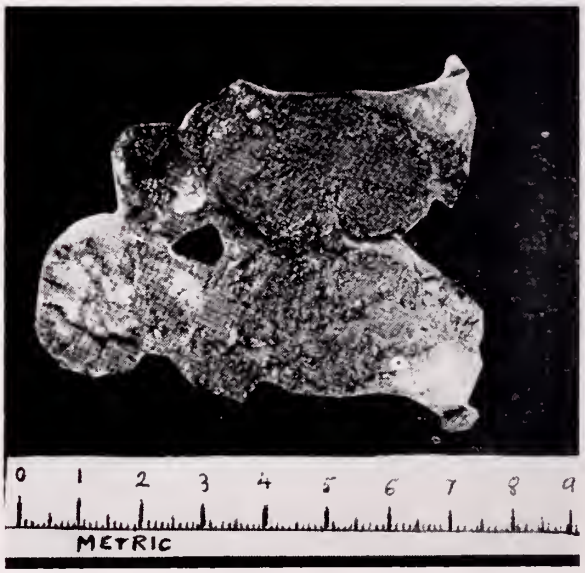

Figure 1. Gross appearance of ruptured tubal pregnancy on section.

lumen was filled with similar blood clot and spongy tissue (Figure 1).

On microscopic examination, the tubal wall was atrophic, and showed marked extravasation of RBC's and infiltration by polymorphonuclear leukocytes, lymphocytes and plasma cells. The mucosa was generally atrophic and contained lymphocytes. The lumen contained RBC's, fibrin and leukocytes. Chorionic villi were seen.

The pathologic diagnosis was tubal pregnancy (left) with abortion (Figure 2).

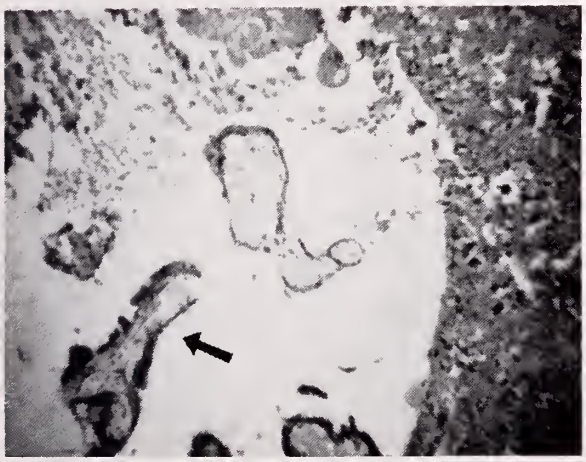

Figure 2. Microphotograph of tubal pregnancy. Arrow points to chorionic villi. At the time of tubal abortion, the coexistent intrauterine pregnancy had reached the 6th week of gestation.

Further Developments and Follow-Up

The patient had an uneventful recovery after surgery and, following blood transfusion, intravenous fluids, continuous Terramycin and analgesics when indicated, became symptom free. She was discharged September 6, 1959.

After leaving the hospital, the patient, with her family, moved to Cleveland, Ohio. She consulted her family physician there November 13, 1959, because she had not had a menstrual period since July 20.

On examination, the uterus was enlarged to a size compatible with a 3½ months' pregnancy, thus rendering it obvious that the patient had become pregnant in the uterus after the July 20 menstrual period. A few days after the office visit, she felt life. We informed her family physician that she had undergone surgery on August 31 and that abortion of the left tubal pregnancy was found at that time.

Thus, it became evident that the tubal abortion had occurred in the sixth week of the intrauterine gestation.

In subsequent months, the patient continued to do well. Blood pressure and urinalysis remained normal; there was a total weight gain of 14 pounds.

On April 27, 1960, the estimated date of confinement, she delivered spontaneously a mature, well-developed, normal male infant after 6½ hours labor. The infant's weight was 7 lbs., 2 oz., length 19½ inches, chest circumference 13 inches and head circumference 14½ inches.

Discussion

Greenhill emphasized the importance of differentiation between combined pregnancy and compound pregnancy.

In combined pregnancy, existence simultaneously of intrauterine and extrauterine gestations resulting from one fertilization, or two separate fertilizations within a short period of time, is dealt with (Figure 3).

Compound pregnancy means the superimposition of an intrauterine gestation on a previous extrauterine pregnancy, generally a lithopedion[5].

The pathogenesis of combined pregnancy is explained by several theories and logical assumptions, among which the latest is that combined pregnancy occurs with fertilization of two ova[8]. Winer expressed the opinion that "regardless of the time of ovulation or fertilization, one ovum proceeds normally to the uterine cavity while the other becomes arrested in its course[7]."

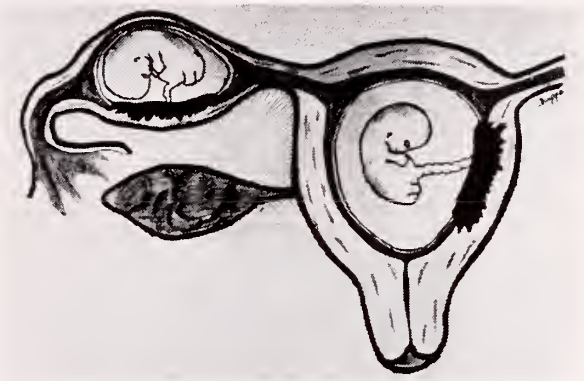

Figure 3. Transectional view of combined pregnancy by artist's conception.

The causes of failures of the arrested ovum to proceed to the uterine cavity are many: infantile anatomical or physiological features of the tube, nervous or anatomical disturbances of the propulsive process, diverticula, malformations, previous surgery and pathologic changes caused by previous inflammation, to mention a few. Most frequently the second pregnancy is located in the tube[8].

Endometrial Changes

The endometrial changes in ectopic pregnancy have been reported as of limited value[9]. Romney found decidual type endometrium in only 19 per

cent of 115 ectopic pregnancies. Pildes and Wheeler[9] reviewed 50 endometrial curettements from 121 ectopic pregnancies. They found that 26 per cent showed an endometrium in the secretory phase without any features suggestive of early pregnancy.

Since not too much is to be gained by examination of endometrial curettements of the ectopic pregnancy, diagnostic curettage is not recommended when the extrauterine pregnancy is suspected clinically.

Summary and Conclusions

1. Since all combined pregnancies arise from two ova, it is expected that there will be two corpus lutea. In the maintenance of coexisting intrauterine gestation, optimal amounts of progesterone are needed; at the time of tubal abortion, therefore, removal of the ectopic conception should not include homolateral oophorectomy.

2. If the coexisting intrauterine gestation is recognized at the time of a laparotomy necessitated by tubal abortion, every effort should be made to retain the simultaneous intrauterine pregnancy. Rest, hormone treatment, vitamins, antibiotics and other such measures will prove helpful.

3. If the coexisting intrauterine pregnancy is not recognized at the time of tubal abortion, curettage for the purpose of obtaining endometrial specimens as a further diagnostic aid should not be attempted because of their limited and insignificant value, also because an early simultaneous intrauterine gestation might be terminated thereby.

4. The presentation of our case serves to emphasize the avoidance of diagnostic dilatation and curettage following tubal abortion because simultaneous early intrauterine gestation can coexist even in cases in which the uterine enlargement is minimal or absent at the time of laparotomy.

By observing the above precautions, preservation of the intrauterine component of a combined pregnancy permitted the delivery of a full-term normal infant, although in the sixth week of the intrauterine gestation salpingectomy was necessitated by the rupture of the coexisting tubal pregnancy.

Acknowledgment

We are indebted to Dr. Benjamin Newman, Pathologist, Herbert J. Thomas Memorial Hospital, for the microphotograph, and to Mrs. Ruth Duppee, R. N., for the artist's conception in Figure 3.

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The Machine and the Doctor

It is clear enough that the electronic computer can become a powerful ally of the physician in diagnosis and in keeping knowledge of specific diseases up to date. It probably will help point up areas where there are important deficits in knowledge. As new information from research is developed it can always be fed into a machine and thus continually refining and keeping up-to-date the description of the disease involved.

It is clear enough that the time is not far distant when computers will become an important aid to physicians in diagnosis and treatment of disease. But let us not lose heart. The physician will not be replaced by the machine any more than excellent textbooks can take the place of the doctor.—L. H. N., in Connecticut Medicine.

Dermatorrhexis (Fragile Skin)*

(Case Report)

Bert Bradford, Jr., M. D., Samir Shabb, M. D., and Grover B. Swoyer, M. D.

Dermatorrhexis, or fragile skin, is a rare condition characterized by paper-thin, glistening skin which breaks easily on minor trauma. Trivial injuries result in lacerations that gape widely. There usually is a minimal amount of bleeding due to retraction of skin edges. The latter are friable and tear easily, rendering suturing of these lacerations difficult. The consistency of the skin has been described variously as similar to wet blotting paper,[4] baked apple peeling, skin of the eyelid and cigarette paper.[2, 8] Taping of the wound edges rather than suturing has been suggested because of the friability of the skin. The condition usually is manifested over bony prominences, particularly the shins and prepatellar areas.

Dermatorrhexis, as a rule, is considered part of a more common condition, namely, the Ehlers-Danlos syndrome. The latter was first described in 1889.[6] It is thought by some to be a constitutional dyscrasia of the mesenchyme,[1] and has the following additional manifestations:

1. Elasticity of the skin: The skin in some areas can be stretched from 6 to 8 inches[1] and when released returns to its original appearance.

2. Hyperextensibility of the joints: This may be severe enough to interfere with the ordinary functions of the joints and may require corrective surgery. It seems to improve with advancing age.[4]

3. Fragility of the vessels: Hematomas seem to develop readily in these cases. Ecchymosis may develop. Wounds and punctures do not bleed easily because of the elasticity and retraction of edges causing pressure over the severed vessels. All tests for blood dyscrasia usually are negative. The Rumpel-Leede test may be positive.

4. Subcutaneous calcification and ectopic bone formation:[3] Pseudocysts form under the skin from repeated small hematomas, later calcify, and give a typical x-ray appearance. The cysts can be felt under the skin. The process is not to be confused with the characteristic parasitic involvement of deeper structures.[6, 8, 3]

5. Internal changes: These include eye manifestations, hiatal hernia, megalo-esophagus, megacolon and diverticula.[4] Repeated spontaneous pneumothorax may occur, with resulting subcutaneous and mediastinal emphysema.[4, 5] In some cases, there is a tendency to hirsutism, to some extent.

6. Associated malformations: Webbing of the fingers, high palate, congenital cardial defect, ectopic lens and congenital kidney have been mentioned.[6, 4]

Histological findings are not always typical. The epithelial layers usually are flattened. There is more histological change in the dermis where there usually is a normal or an increased number of elastic fibers.[6] The collagen fibers generally are diminished and often fragmented. Occasionally there is some edema among the fibers. Vascular changes may be apparent.

Treatment

Treatment for the most part is supportive. Patients should guard against any kind of trauma to vulnerable areas. Lacerations should be taped or, when possible, sutured, preferably without the use of a local anesthetic. The wounds tend to heal very poorly and slowly.

Case Report

Mrs. L. L., a 37-year-old white female, was first seen by us in 1953. She had a gaping laceration over the anterior aspect of the right leg, 6 inches below the knee. The wound was the re-

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***From the Surgical Service, Memorial Hospital, Charleston, West Virginia.**

Submitted to the Publication Committee, June 29, 1961.

sult of a minor injury. She previously had had twelve lacerations in similar areas. During the succeeding five years from the date of our first examination ten more lacerations of the shins were treated by us.

The patient had experienced no significant trouble regarding her legs until she was 18 years of age, when a slight pigmentation of the skin over the shins developed. At 22 years of age she noticed that the skin over the shins broke easily on the slightest trauma. Since that time she had had numerous lacerations, but had noticed that these did not occur as frequently when she was pregnant, nor following the deliveries. She had had three pregnancies and following each one the frequency and extent of the lacerations diminished.

The lacerations always have been uniformly gaping with minimal bleeding (Figure 1). There has been no pain and on suturing, local anesthesia has not been necessary. On one occasion novocain was used and the lacerations took months to heal. Through experience it has been found that in suturing these lacerations the best method is to put in all the sutures before attempting to approximate the skin edges. Even this method has failed at times and we have resorted to taping. The lacerations frequently disrupted and healed by secondary intention.

Figure 1. Photograph of both legs (anterior aspect). The left leg shows wound before suturing and pigmentation of the skin is present as result of previous lacerations

On examination, the shins had a shiny appearance; the skin was very thin and velvety. There were multiple scars. There were no calcifications nor subcutaneous nodules. The patient enjoys excellent health otherwise.

There is a slight tendency to hirsutism. The skin is not elastic and the joints are not hyperextensible. The only other positive finding was a soft, apical, systolic murmur. There was no cardiac enlargement and no thrill. The Rumpel-Leede test, bleeding time, clotting time and platelet count were normal. A skin biopsy was performed on two occasions (Figure 2). They were reviewed by several pathologists who agreed on the following observations:

Figure 2. Photomicrograph of skin biopsy from anterior aspect of leg. H & E x 100.

The epidermis was slightly thinner than usual while the dermal region was decreased in thickness with decreased amounts of collagen which had a compacted appearance and extended in a compact fashion to the basilar layer of the epidermis. There was a moderate increase in the elastic fibers. The skin appendages were intact, although several hair follicles were compressed by the surrounding dermis. In the upper subcutaneous tissue there was an artery with a narrowed lumen with a thickened wall due to subintimal collagen showing basophilic degeneration. In other areas there was fragmentation of the dermis with areas of recent hemorrhagic infiltration. In one section there was a slight pericapillary infiltration by lymphocytes.

Summary

A case of dermatorrhexis involving the skin of the legs, without other characteristics of the Ehlers-Danlos syndrome except mild hirsutism, easy bruising and faint cardiac murmur, is presented. The patient had had 22 lacerations of the shins, all resulting from minor trauma. Each pregnancy had definitely improved the condition of the skin, with a decrease in the frequency and severity of the lacerations.

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Physical Fitness of the School Child

A CHILD needs guided athletic activity in school for several reasons. Beginning way back at ages six or seven years, certain hormones are secreted which act to build muscle tissue. Such tissue needs to be exercised or it will not grow and develop properly; indeed, it will atrophy. An extreme example of the results of muscular disuse is the child at complete bed rest, with rheumatic fever for instance, or in a body cast. He loses both muscle and bone substance. Such body wastage is a recognized and serious medical problem.

A child needs guided athletic activity during the school years because his muscles have the potential to grow for only a limited time, during the period of general growth. If these muscles are not properly used during this time, they cannot be developed later. Indeed, the Army found that it might take a middle-aged man and thin him down, put him into "trim," but it could not give him muscles if he had not developed these in his youth.

Athletic activity develops coordination and motor skill in the child and he learns to use his muscles with agility and efficiency. This is important if it only allows him to enjoy life more fully: to play a better game of golf or tennis.

Every child needs the experience of athletic competition to help to train him for the competitive situations which he must face and master in successful living. And athletic activity offers a physical outlet to the frustrations and pressures of modern life. The commonest modern psychoneurosis is probably the "effort syndrome" with its fast pulse and respirations and its incapacitating anxieties. This seems, in many ways, to be the opposite of the trained physical state.

Last, in all candor, a child needs athletic activity in order to make him (or her) more presentable, esthetically, as a human being.—Stuart S. Stevenson, M. D., in Journal, Medical Society of New Jersey.

Special Article

How the West Virginia University Medical Center is Contributing to Better Rural Health in West Virginia*

Kenneth E. Penrod, Ph. D.

In the best tradition a keynoter is supposed to point out problems but is freed from the responsibility of advancing any solutions to these problems else he unduly usurps the function of the remainder of the discussion he is keynoting. So I shall avail myself of the privileges of this position and proceed with a certain amount of abandon through and around the general subject of the provision of health care to that segment of our population not forced by circumstances to live in one of our urban communities.

Before getting very far into this subject, and especially as it relates to my assigned topic, the role of West Virginia University Medical Center, let me make it quite clear that despite the wishful thinking that has gone on in some quarters, the production of physicians by the West Virginia University School of Medicine, even when it is graduating full classes, is not going to solve all of the problems of providing rural medical care, at least not alone and without a lot of help from a great many sources.

The provision of health services, the term with broader meaning and one that I prefer to "practice of medicine," has undergone a great deal of change over the past 50 years. The factors bringing about this change are many and varied and a little time can be profitably spent looking at some of them.

Great Expectations

In the recent past there has been a sizeable increase in what the people of this country have come to expect in the way of health care. With increased realization of what medicine can offer, brought about largely through improved means of communication, more and more people are demanding better and better care. During the past 30 years the average number of visits to a physician in one year has increased some two and one-half times and, further, as the population of the country continues to grow, especially in view of the anticipated disproportional increases in the very young and in the older age groups, both of which tend to require additional amounts of medical attention, the average number of physician visits can be expected to continue to increase.

Concurrent with the rising demand for more and better medical coverage has been a striking change in the social pattern of meeting the cost of this coverage. As recently as 20 years ago only about 12 million people in the United States were financially protected by some form of health insurance. Now this number has increased by well over tenfold and nearly three-fourths of the population participate in some form of prepayment plan to cover hospital costs. The increase in protection against surgical costs has been even more dramatic but, unfortunately, there are serious deficits remaining in the present structure of full cost coverage for health care, especially in relation to the everyday visits to a physician and for the long term, chronic illnesses, which appear to be on the increase. Meanwhile, the changes in medicine itself tend to increase the demand. It hasn't been too long ago that the feeling was prevalent among many informed sources that, with the advent of the sulfas and, later, the antibiotics, the need for health care would materially decrease in the future. But such has not been the case. While many previously serious, acute illnesses have now largely disappeared, they have been replaced by new conditions more demand-

The Author

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*Presented before the 14th Annual Rural Health Conference at Jackson's Mill on October 5, 1961.

Submitted to the Publication Committee, October 5, 1961.

ing in their care. Now many who might previously have succumbed to acute infections, live to develop heart disease, cancer, nervous diseases and the multiple debilities associated with older age.

Medical Research: A Broadside

But the real miracle of medicine of our age is not limited to the so-called "miracle drugs." It is the tremendous progress brought about by research on a broad front—the production of new knowledge and techniques at a rate undreamed of a generation ago. Surgery, not very long ago believed to be developed to a stage where only minor refinements were possible, has made tremendous strides into hitherto forbidden areas such as the inner chambers of the heart itself. The radiologist, with his sometimes awesome and seemingly always expensive new tools, is now accomplishing the impossible regularly. The internist, with his vast and increasing armamentarium of diagnostic equipment and therapeutic drugs, is now a living example of the conundrum "the difficult we do now, the impossible will take a little longer."

What does all this mean to the practice of medicine today and tomorrow? It means that the days of the "little black bag" are largely behind us. The thing a physician needs to practice medicine now and in the future just won't fit into the little black bag—or even a large black bag. You don't really wish him to come to the home much any more—he's too handicapped when he gets there. What I am trying to say is that good health care today is so complex as to require the patient to come to it rather than for it to come to the patient. Despite many concepts to the contrary, this is the real reason why physicians are more and more reluctant to make home calls.

Another important concept in modern health care bears scrutiny. And for this, let us depart for the moment from the role of the physician.

Recent Bureau of Census figures tell us that as of today there are in the United States some two and one-half million persons employed in the health care industry, only one in ten of whom is a physician. In all there are some 20 other recognized groups such as nurses, pharmacists, dentists, physical therapists, occupational therapists, social workers, medical technicians and a host of others. Each has invested considerably in education and training to provide a specialized service which has come to be vitally important to the health of the population. But, by the very nature of the services these people are prepared to provide they must work together in a clinic or hospital setting. But when their services can be utilized they are prepared to augment to an enormous degree the care of the physician.

We in the so-called "ivory towers" of medical education are sometimes accused of gearing the education of the young physician to the hospital setting so as to make him dissatisfied with solo practice in the rural communities where his services are so badly needed. I find myself unable to apologize for this and I would agree it is true. But I hope you will let me defend this position for a moment.

For the reasons I have outlined I just do not see how good medicine can be practiced in the future on a solo basis, removed from contact with hospital and clinic facilities for diagnosis and treatment. And you must remember the students we are teaching in medical school today will be practicing medicine for the next fifty years or so. We must educate them for the practice of tomorrow, not yesterday, nor even today. And unless my crystal ball is badly out of focus, the demands on them tomorrow are going to differ materially from those today.

So if we can accept the concept that provision of health care in the future will increasingly involve aid to the physician in the form of specialized helpers and specialized equipment, he can't "go it alone" in every hamlet unprepared to support such a complex structure. Health care will have to be on a regional basis, supported by cooperative effort. I await with interest the development of some discussion along these lines today.

Specialist vs GP

Perhaps a word should be said about the recent trends towards specialization in the practice of medicine, as opposed to the development of the popular figure known as the general practitioner of medicine. This trend is, I am quite sure, with us to stay and there really isn't anything anyone can do about it in a free America. There are many factors bringing about this trend, but the greatest no doubt is the vast amount of knowledge now known and being continually developed in all fields of medicine making it humanly impossible to encompass more than a limited area. A medical student in his development becomes so impressed with what is known in each of the various fields of medicine to which he is exposed, that he becomes dissatisfied with knowing only a small part of the tremendous body of knowledge he could know, and usually decides he would rather know a great deal about a part of the whole field than a little about the entire field.

With the vast increase in complexity of diseases people present, and the other factors bringing about expertization in diagnosis and treatment of limited areas of medical practice, the

general practitioner in the older concept finds himself increasingly handicapped in treating all but a few of the less complex medical conditions.

But this age of specialization has brought with it one difficult problem for which a solution must be found. Where there once was no question in anyone's mind when he was ill as to whom he should see, there now may be a good deal of question. Once he called, or went to see, his family doctor. But now, confronted with a phone book showing a long list of physicians having in their listings the sentence "practice limited to —," the patient often is called upon to make his own preliminary diagnosis in order to know which of these physicians he should see.

Group Practice

As I see it there are two possibly acceptable solutions to this problem for the future. One that is becoming increasingly prevalent now is the community clinic. Here the central figure is usually the internist—a physician trained both in depth in a limited area of medical practice and in breadth, at least sufficient to make reliable preliminary diagnoses and to know to whom to refer a specific problem for further care. A clinic group, representing pooled talent for coverage in depth, at least in many areas of health care, can, in one stop, provide excellent care for the major share of the ills of a patient. Too, such a clinic group now usually has among its members a variable number of ancillary specialists prepared to give expert services in procedures recommended by the physician. And not to be overlooked is the fact that such group practice permits a sharing of the enormous and rising costs of maintaining the facilities for modern medical practice.

The Public Health Nurse

Another possible solution to this problem of knowing whom to see rests in the increased utilization of a person relatively unknown to many people—the public health nurse. Like medicine, the field of nursing is undergoing rapid development, both in depth and in breadth. Just as medical practice has evolved a long way from the horse and buggy doctor, so has nursing come a long way from the demure bedside back rubber.

Nursing education, especially that like the rapidly developing program at our own University, is designed to produce both an educated and a trained nurse, with emphasis on the former. She will be a college graduate with all that that implies. Increasingly, I believe, she will be capable of assuming an important role in society as a consultant on health problems—what to do and where to do it. In some measure at least I believe we can in the future look to the very capable public health nurse in the community for sound advice on where and how to care for health needs.

The Role of the WVU Medical Center

So, at long last, getting around to the topic I was asked to speak on today—how the West Virginia University Medical Center is contributing to better rural health in West Virginia—I believe I can dispose of this subject rather succinctly. In short, the West Virginia University Medical Center is dedicated to the production of well educated, well trained young people in all of the many facets of the health care industry.

At this moment we are teaching future physicians, dentists, college degree nurses, pharmacists, medical technicians and dental hygienists. We look forward to further expansion of each of these programs as well as the addition of others so long as our financial resources will permit.

Our job is to see to it that each of these students has the very best educational opportunity available in the United States—that his talents will be developed to the very highest degree. But we cannot assign him to practice in any given location in a free America. We can, and shall, give every subtle encouragement to location in those areas where services are most needed, but in the long run it will be up to all of us—the citizens of this State of West Virginia—to make life sufficiently attractive in our communities as to make these graduates wish to stay among us. And I believe, with all of us working toward this end, it can be done and we can look forward to a brighter tomorrow.

. . . the most exhausting thing in life is being insincere.

ANNE MORROW LINDBERGH.

95TH ANNUAL MEETING

of the

West Virginia State Medical Association

The New West Virginia Wing

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AUGUST 23-25, 1962

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The President's Page

Don't Let The Smoke Get In Your Eyes

As of this date, the physicians of West Virginia are confronted with two major problems which are interrelated, in that both are concerned with providing health care for a segment of our population who have passed sixty-five years of age. The solving of the first will play a major role in preventing the second. The first is concerned with the administration of the Kerr-Mills Law (MAA), the second with the continued effort of the administration to foster some type of federally controlled health care associated with OASDI (proposed King-Anderson legislation).

The Medical Assistance for the Aged program can provide medical care for those who need it, only if legislators, administrators and physicians work together with a genuine desire to see it succeed. The program was designed to provide medical care for those of our citizens who are able to take care of their daily needs but who are unable, without undue hardship, to cope with major medical expenses and hospitalization.

I am sure all physicians would be very happy to provide the best in medical care for those who have been described as "medically indigent," at fees commensurate with their economic status. We have been doing this for untold generations, long before our numerous welfare programs were conceived. All citizens, however, should object when people are given assistance, medically or otherwise, when they are financially able to provide for themselves. This has occurred in numerous instances during the fifteen-month existence of our MAA program, as a result of easy eligibility and inadequate investigations. All monies, State or Federal, can come from but one source and that is from the pockets of our citizens. Everyone agrees that welfare funds should be spent judiciously and only on those who can qualify as being needy. However, since the providers of medical services are also taxpayers, and as such have helped contribute to these funds, they are therefore entitled to a just share for services rendered to their patients.

Don't let the smoke from the conflagration kindled by the recent communication, "Medical Services Letter No. 4" from Mr. Calvin Cook, evoke precipitous action or blind you to the fact that it is mandatory that we resolve our differences in an equitable manner with the Department of Welfare. Failure of the MAA program in West Virginia could very well trigger the passage of the King-Anderson legislation early in the next Congress. Those of you who have not acquainted yourselves with all the provisions of this proposed King-Anderson legislation, which primarily supplies hospital care, nursing home care and home health services, may not be sufficiently concerned about its enactment into law. It is not this specific bill but its inclusion in the Social Security format that gives each succeeding Congress the power to enlarge the program. Ultimate complete socialization of medicine would follow.

Both Governor Barron and Commissioner Smith have stated that they wish to continue the Medical Assistance for the Aged program. Eligibility regulations have been tightened. I have been convinced that the "emergency" will be of short duration. As physicians, we should support any fair program that may evolve in the future and assist in every way possible to keep it healthy.

D. E. Greeneltch, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.

EDITORIALS

THE URINARY BLADDER DURING WEIGHTLESSNESS

Within the past few years a number of physiologic studies have been made on individuals during the state of weightlessness. It will be recalled that weightlessness occurs when the force of the earth's gravity is exactly balanced by the flyaway tendency of centrifugal force. In the course of these studies it was observed that there was a diminution, or a total absence, of urgency to urinate. Indeed, Ward *et al.* in 1959 working with 26 individuals found this to be true in 58 per cent of the subjects.

Some investigators feel that a dulling or a loss of the urge to urinate may be fraught with danger, in that the urinary bladder becomes so large that it may burst. This can, of course, in a large measure be prevented if the astronaut empties his bladder at periodic intervals. It has been shown that urination can be performed readily during the weightless state.

The present consensus is that the urge to urinate is produced by sensations arising from the stretch receptors in the musculature of the bladder. Studies on the body while in a state of weightlessness suggest the possibility that the weight of the fluid pressing against the floor of the bladder is responsible for the sensation of bladder fullness. It may be, then, that the primary zone lies in the trigone of the bladder rather than in the stretch receptors in the walls. If this is true, a new concept of the physiologic process of the desire to urinate must be accepted. Complete proof, however, is lacking, and cannot be obtained until an American has been orbited in a satellite for many hours.

It is extremely interesting that studies during the weightless state, a relatively newly investigated field, might change a concept which has been generally accepted for a long time. This observation may be regarded as an example of serendipity, that is, a finding not anticipated during the designing of the experiment.

HERE'S LOOK AT STATE'S MEDICAL FUSS

Behind the scenes in all the recent furor over the state's medical care for the aged program are some interesting developments which possibly could place West Virginia in the national spotlight once again. There is growing fear among the medical profession that the reported financial crisis in the state's medical care for aged program may be used at the national level in support of renewed efforts to gain Congressional action on the controversial King-Anderson Bill.

Ward, J. E., Hawkins, W. R., and Stallings, H. D. J. Aviation Medicine 30:572, 1959.

The King-Anderson proposal is the Administration's bill to provide medical aid for aged under Social Security. It has been under heavy attack by the American Medical Association which labels it nothing more than socialized medicine.

In answer to this plan, the AMA provided strong support to the Kerr-Mills bill which was enacted into law last year with Republican backing along with certain elements of the Democrat party. The Kerr-Mills legislation allowed states to participate by choice and to whatever extent they deemed necessary. The federal government provides matching funds to the states for this program.

West Virginia was one of the first states to embrace the plan when the Legislature passed necessary enabling legislation. Now a year later the program has encountered difficulty and drastic cutbacks have been announced by State Welfare Director W. Bernard Smith in both services and eligibility requirements.

First reports from Smith's office stating that upwards of $1.4 million already have been spent for the program since July 1 with an estimated "two million dollars in doctors bills remaining to be paid" has since been corrected. It should have been stated that the two million dollars was for all categories of aid—hospitals, doctors, drugs, nursing homes, etc.

This correction in the earlier press announcements was made as a result of the *News-Register's* persistent efforts to trace down the true facts after the Ohio County Medical Society challenged the first news story.

However, if the figures now released are accurate a total of $2,796,679.58 has been paid out for aged medical care in West Virginia during the period covering October, 1960-October, 1961. It must be pointed out that the state only appropriated $1.4 million for the program and with federal matching funds had $3.8 million to carry on.

We have checked numerous sources in an attempt to learn just how many other states are now participating in the medical care for aged program as provided under the Kerr-Mills law and there are conflicting reports and conflicting interpretations.

On November 26 of this year Jules H. Berman, a representative of the Administration's Department of Health, Education and Welfare addressed the American Medical Association on this very subject.

In his speech he said that as of November 1, 1961, 21 states had programs in operation under the 1960 legislation. During the same talk, he said only five states had what he called "comprehensive plans—New York, Louisiana, North Dakota, Oregon and Massachusetts.

Berman's definition of a comprehensive plan involved those that provide hospital care, nursing home care, and physicians' services without significant limitations as to the nature of the patient's illness, the unit cost of care, or number of days of care or visits to or from a doctor.

United Press-International checked for this same information with the Health, Education and Welfare department in Washington and were told that only three states—New York, Massachusetts and North Dakota—have comprehensive programs. The same source said 16 other states have started some kind of program under the Kerr-Mills law.

The most recent issue of the American Medical Association's magazine states that 30 states have passed necessary enabling legislation to provide for aged medical care under the federal aid program. From the AMA's viewpoint this is proof that the Kerr-Mills legislation does provide for a workable plan to aid the aged. The doctors supporting this program state that this is remarkable progress considering the law is only a year old and many states want to begin conservatively so as to discover what the needs are and what can be done.

They fear now that the trouble reported in West Virginia might be used by those arguing the need for the King-Anderson legislation.

In reviewing the situation it would appear that West Virginia got itself involved in an overly ambitious program to begin with, coupled with easy eligibility requirements. For example, before the cutbacks were announced, an individual owning a home valued at $20,000 or less was eligible. Also persons with liquid assets totaling $5,000 in savings, stock, bonds and cash surrender value of life insurance.

Even more revealing is the fact that under West Virginia's plan, until just recently modified, remedial care or services for the aged included eyeglasses, dentures, and any type surgery, x-ray therapy, out-patient psycho therapy and, get this —WIGS!

All of this seems to point out that better administration of the program is needed in West Virginia and the medical societies in the state should keep a closer eye on what is happening under the plan. After all the medical profession supported this program and if it is feared now the West Virginia experience will be used to defeat the plan then their stake in this matter is even greater.—*Harry Hamm, in Editor's Corner, Wheeling News-Register.*

GENERAL NEWS

Proceedings of AMA Clinical Meeting in Denver

Several West Virginia physicians attended the 15th Annual Clinical Meeting of the American Medical Association which was held in Denver, Colorado, November 26-30. Total attendance was 6,138, including 2,976 physicians.

Leonard W. Larson, M. D.

Drs. Charles A. Hoffman of Huntington and Frank J. Holroyd of Princeton, official delegates from the West Virginia State Medical Association, were present at the meeting and attended all sessions of the AMA House of Delegates. Doctor Hoffman also served as a member of the reference committee on "Miscellaneous Business."

Dr. D. E. Greeneltch of Wheeling, president of the State Medical Association, attended the meeting and also participated in a conference on "Recent Developments in Federal Medical Care Programs" which was held on Sunday, November 26, the day prior to the formal opening of the meeting.

State Resolution Adopted

The AMA House of Delegates adopted unanimously a resolution offered by the West Virginia State Medical Association, concerning "Cuban Physicians in Exile." The resolution had been adopted by the State Medical Association's House of Delegates at the annual meeting in August.

The intent of the resolution was in support of efforts which would help solve the problems of exiled Cuban physicians and at the same time maintain high standards of medical care for American citizens.

The resolution follows:

WHEREAS, Some six hundred of our Cuban medical colleagues have been tyrannically compelled to leave their country, and are now temporarily domiciled in Miami, Florida, where many of them are seeking any type of employment as a means of support during their temporary exile; and

WHEREAS, The services of these Cuban physicians may be effectively utilized, both in the areas of private practice and in hospital staffing; therefore be it

RESOLVED, That the House of Delegates of the American Medical Association urge the Medical Licensing Board of the States to use means afforded them by statute and by regulation in an effort to utilize the services of these physicians in any area where a need exists; and be it further

RESOLVED, That the House of Delegates of the American Medical Association at the 1961 Clinical Session in Denver, Colorado, support any constructive effort made in the solution of this problem.

Summary of Denver Meeting

The following summary of the Denver meeting was prepared for publication by Dr. F. J. L. Blasingame, executive vice president of the American Medical Association:

Social Security health care, relations with the American College of Surgeons, organization of the American Medical Political Action Committee, medical discipline and polio vaccine were among the major subjects acted upon by the House of Delegates at the American Medical Association's 15th Clinical Meeting held in Denver, November 26-30.

Sounding the keynote for the Association's campaign to oppose enactment of the King-Anderson type of legislation in 1962, Dr. Leonard W. Larson of Bismarck, N. D., AMA president, told the opening session of the House that proposals to incorporate health care benefits into the Social Security system "would certainly represent the first major, irreversible step toward the complete socialization of medical care."

The compelling issue, Doctor Larson declared, is socialization versus voluntarism—or compulsion versus freedom of choice. He predicted that courage, determination and the will to win on the part of physicians will bring defeat of the King-Anderson bill in Congress next year.

Pointing out that "we are engaged in an historic struggle to preserve our country's unique system of medical care and our stature as a profession," Doctor Larson said:

"We are for voluntarism. We do not believe that Americans, acting either as citizens or as patients, require central direction from government in their choice of doctor or hospital, in the spending of their health care dollars, or in their selection of the health services and facilities best suited to their own individual needs.

"We take our stand for voluntary cooperation, for preservation of the historic federal-state organizational structure, for individual responsibility, for help for those persons who need help."

Doctor Larson emphasized that the AMA will continue to give primary attention to implementing the Kerr-Mills Act in the states, promoting voluntary health insurance and prepayment plans designed for the aged, and upgrading nursing homes.

The House of Delegates gave enthusiastic approval to Doctor Larson's address and took several actions reaffirming strong support for the Kerr-Mills program to aid the needy and near-needy aged, and urging a concerted, determined fight against Social Security health care proposals in Congress.

The House advised all state and county medical societies to recognize the impending threat and to prepare now for any eventuality by continuing to oppose any scheme which tries to impose a substandard system of medical care on the American people.

"United, as well as individual, effort is essential," the House declared. "To stop short of our total effort is to invite disaster and to let loose upon our beloved America irreversible forces which will ultimately destroy her. We cannot and we must not fail."

American College of Surgeons

The House agreed with the intent of five resolutions which expressed strong dissatisfaction over recent statements by a spokesman for the American College of Surgeons, and it also approved a Board of Trustees report informing the House that arrangements have been made for a January meeting with the ACS Board of Regents to discuss that organization's recent statements and policy positions. The report expressed hope that the meeting "will lead to a unification of effort in behalf of American medicine."

The House instructed the Board of Trustees to take the five resolutions to the January meeting and to report to the delegates as soon as possible on the results of the meeting. In taking the action, the House approved a reference committee report which said:

"Your reference committee believes the public airing of disagreements between large segments of medicine can only confuse and shake the confidence of the public in the medical profession and distort the true image of medicine which the American people should have.

"However, in its hearings upon the several resolutions relating to the recent statements of the American College of Surgeons, all those who testified were in opposition to the actions and statements of the ACS. The majority of those who spoke were Fellows of the American College of Surgeons.

"Your reference committee has no wish to fan the flames of controversy ignited by the statements of the American College of Surgeons. On the other hand, the committee feels the House has an obligation to its membership—which includes physicians in all types of practice—to agree with the indignation manifested by the introduction of these resolutions and in the discussions before the committee.

"This is all the more important because the position of the American College of Surgeons is based on an incorrect interpretation of the action of this House which in no sense is a retreat from its position of firm opposition to fee splitting."

American Medical Political Action Committee

The House heartily approved the purposes and goals of the recently-organized American Medical Political Action Committee and urged all physicians, their wives and interested friends to join AMPAC and other political action committees in their states and communities.

"Effective political action must be carried on at the local level and effective implementation must be done by local groups of physicians," the House said. "The formation of AMPAC recognizes the need for a national medical political action committee to coordiate the political activities of physician groups at all levels throughout the country."

The purposes of AMPAC, which is an organization separate and distinct from the American Medical Association as required by federal law, are:

1. To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.

Medical Meetings, 1962

The following is a partial list of national, state and district medical meetings scheduled for 1962:

Jan. 15-17—Medical Licensing Board, Charleston.
Apr. 9-12—AAGP, Las Vegas, Nevada.
Apr. 22-25—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
May 25-27—W. Va. Chap. AAGP, Charleston.
June 6-8—W. Va. PH Association, Huntington.
June 24-28—AMA Annual Meeting, Chicago.
June 28-29—Seminar on "The Adolescent," WVU Medical Center, Morgantown.
Aug. 16-18—W. Va. Hospital Assn., White Sul. Springs.
Aug. 23-25—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 13-16—PG Institute, Martinsburg.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.

2. To encourage physicians and others to understand the nature and actions of their government as to important political issues and as to the records and positions of political parties, officeholders and candidates for elective office.

3. To assist physicians and others in organizing themselves for more effective political action and for carrying out their civic responsibilities.

4. To do any and all things necessary or desirable for the attainment of the purposes stated above.

Medical Discipline

The House received from the Council on Constitution and Bylaws a proposed amendment which would have made it possible to implement a recommendation by the Medical Disciplinary Committee that was approved by the House at the June, 1961, meeting. This recommendation was to change the bylaws so as to confer original jurisdiction on the Association to suspend and/or revoke the AMA membership of a physician found guilty of violating the Principles of Medical Ethics or the ethical policies of the Association, re-

gardless of whether or not action has been taken against him at the local level. However, after considerable discussion on the floor of the House, the proposed amendment was referred back to the Council on Constitution and Bylaws.

In another action on medical discipline the House approved the expanded activities of the Judicial Council, which has taken over permanent responsibility in that area, and said that the Council program should benefit all physicians, the public and the profession.

Polio Vaccine

The House adopted a resolution which urged that medical societies at the local, county, district or state levels throughout the United States should encourage, stimulate and participate in surveys to determine the percentage of individuals in each community who have undergone immunizing procedures for poliomyelitis.

The resolution stated that on the basis of the results of the surveys, the local medical society should determine the type of vaccine and the most effective type of program which will be of greatest benefit to the public.

Until such time as all three types of oral vaccine are available, the resolution concluded, the Salk vaccine should be the vaccine of choice for routine poliomyelitis immunization, with the choice of program for administering the vaccine to be determined on a local basis by each county medical society.

Miscellaneous Actions

In considering a wide variety of resolutions and annual and supplementary reports, the House also:

Disapproved of two proposals which would have required that resolutions be introduced 30 and 45 days, respectively, before Association meetings.

Approved a statement that physicians have an ethical obligation to participate in medical society activities and express their opinions fully and freely.

Reaffrmed AMA policy that it is not considered unethical for a physician to own or operate a pharmacy provided there is no exploitation of the patient.

Agreed with the Judicial Council that the physician himself is responsible for the control and custody of drug samples once they come into his possession, and in the high tradition of the medical profession he should not dispose of them in any way that could cause harm to others.

Commended those constituent medical societies which have moved forward in the area of human relations by eliminating membership restrictions based on race or color. In connection with the same subject, Dr. Peter Murray of New York City, retiring after 12 years of service in the House, told the delegates in a farewell address that Negro physicians now have some kind of medical society membership in every state except one.

Approved a recommendation that a special House committee be appointed to investigate all facets of the operation of the Joint Commission on Accreditation of Hospitals.

Agreed with the Board's choice of Miami Beach, Florida, as the site for the 1964 Clinical Meeting.

Approved the combining of the American Medical Education Foundation and the American Medical Research Foundation into the American Medical Association Education and Research Foundation, effective next January 1.

Deferred action on a proposed study of fund raising by voluntary health agencies, pending the development of additional information by the AMA Committee on Voluntary Health Agencies.

Reaffirmed the previous policy that physicians should have the privilege of prescribing drugs by either generic or brand name.

Approved the principle of income tax deductions for medical care of the aged.

Recommended, in reviewing the Medicare Program, that all county medical societies in the area surrounding armed forces hospitals make a serious attempt to establish formal liaison with the physicians on those hospital staffs.

Endorsed the administration of indigent medical care programs developed in cooperation with local medical organizations as a legitimate activity of state and local health departments.

Urged the elimination of all "categories" in programs of assistance to the needy at the federal and state level, with all assistance provided through a single program.

Referred to the Council on Medical Service a resolution proposing the use of state and federal tax funds to provide voluntary prepayment health insurance protection for the aged. In a related action the House approved of experimentation with prepayment plans under assistance programs.

Urged more vigorous promotion of voluntary nonprofit prepayment health plans.

Urged every physician in the United States to use automobile seat belts.

Recommended, as a civil defense measure, a mass immunization program for the general public.

Suggested that the Board of Trustees continue its negotiations to develop a group disability insurance program for AMA members.

Concurred in the Board's appointment of a special committee to study the organizational status of AMA Sections, the functions of the Scientific Assembly and existing procedures for establishing medical certifying boards.

Instructed the Council on Medical Education and Hospitals to study the present and potential contribution of the American Board of Abdominal Surgery to the advancement of the art and science of surgery and the betterment of public health, to determine whether it should be approved as a recognized examining board.

Approved and commended the objectives and program submitted by the Committee for Liaison with National Nursing Organizations.

Recommended that the Secretary of Defense consider the advisability of developing a training program for reserve medical officers.

Awards and Donations

The AMA Board of Trustees presented a special citation to the producers and cast of The Donna Reed

Show for its "contribution to public understanding of the high ideals of the medical profession." Carl Betz, who portrays Dr. Alex Stone on the television show, received the award from Dr. Hugh H. Hussey, Jr., AMA Board chairman, at the Wednesday Session of the House.

Contributions totaling $435,275.93 from physicians in six states were presented to the American Medical Education Foundation during the opening session on Monday.

MLB Licenses 25 Physicians To Practice in State

Twenty-five physicians have been licensed as a result of the examination at the fall meeting of the Medical Licensing Board held in Charleston on October 16.

The following physicians were licensed by reciprocity to practice medicine in West Virginia:

Blanco, Jose Garcia, Beckley
Butz, George Wm., Jr., Morgantown
Cobern, Charles Blair, Parkersburg
Danenberg, David, Bridgeport, Ohio
Davis, Donald Paul, Beckley

Fenech, Nicholas Joseph, Man
Goplerud, Dean Roy, Morgantown
Hagley, Ray Russell, Chesapeake, Ohio
Harron, Ray Anthony, Clarksburg
Hughes, Francis Homer, Jr., Parkersburg

Jarsen, Frank Joseph, Charles Town
Judd, Allyn Francis, Beckley
Lucas, Russell Vail, Jr., Morgantown
McKee, Thomas Craig, Huntington
Mock, George Franklin, Cumberland, Md.

Nelson, John Woolard, Morgantown
Nugent, George Robert, Morgantown
Sheils, William Sol, Huntington
Shinkawa, Shigeo, Elkins
Sperow, Clifford, Martinsburg

Stauffer, John Henry, Petersburg
Welton, William Arch, Morgantown
Withrow, Curtis Lee, Charleston
Moomau, Frederick, Petersburg
Yates, Roy James, Beckley

The winter meeting of the Medical Licensing Board will be held at the New State Office Building in Charleston, January 15-17.

Essay Contest

A $500 award will be presented to the winner of an essay contest sponsored by the American Therapeutic Society. The author of the best essay in the field of therapeutics and clinical pharmacology will also receive traveling expenses to the annual meeting of the Society in Chicago next June.

Any scientist or physician in residency or fellowship status, or within three years following residency or fellowship, is eligible to enter the competition. The deadline for receiving manuscripts is March 1.

Further information may be obtained by writing Dr. Oscar B. Hunter, Jr., Secretary, 915 19th Street, N. W., Washington, D. C.

Symposium on Trauma Presented At WVU Medical Center

A "Symposium on Trauma" was presented at the West Virginia University Medical Center in Morgantown on December 14.

The one-day conference was sponsored jointly by the Medical Education for National Defense program of the West Virginia University School of Medicine, and the Committee on Trauma of the West Virginia Chapter of the American College of Surgeons.

Dr. Justus C. Pickett of Morgantown, Chairman of the Division of Orthopedic Surgery at the School of Medicine, presided at the meeting which was arranged for the benefit of those persons concerned with the proper care of traumatic injuries resulting from natural disasters and enemy attack.

Dean Clark K. Sleeth delivered an address of welcome and the first speaker was Dr. Milton C. Covey of Washington, D. C., Professor of Orthopedic Surgery at Georgetown University School of Medicine, whose subject was "Transportation of the Injured Patient."

"Is Your Emergency Room Ready" was the subject of a paper presented by Dr. J. H. Spencer of Newton, New Jersey, Chief of the Department of Surgery at Newton Memorial Hospital.

The final speaker was Dr. Robert H. Kennedy, director of the field program, Committee on Trauma, American College of Surgeons. His subject was "The Patient with Multiple Injuries."

Members of the Committee in charge of arrangements were Dean Sleeth, Doctor Pickett, Dr. Daniel T Watts, MEND coordinator for the School, and Dr. D Franklin Milam, assistant coordinator.

Stamp Honoring Nursing Profession Issued by P. O. Department

A commemorative stamp honoring the nursing profession was issued on December 28 by the United States Post Office Department.

Dedication ceremonies, attended by government officials and representatives of national nursing and allied health groups, were held in the Auditorium of the Department of Health, Education and Welfare in Washington, D. C.

Alfred Charles Parker, noted California artist, designed the four-color stamp. It features a student nurse, whose probationary period is completed, lighting a candle—symbolic of her dedication. Colors are red, black, blue and green.

The four-cent postage stamp was placed on sale throughout the country on December 29.

Huntington Physician Reelected

Dr. Emile Gribovsky of Huntington was relected to a three-year term as Governor of the West Virginia Chapter of the American College of Gastroenterology during the recent annual meeting which was held at the Sheraton-Cleveland Hotel in Cleveland.

New Association Members

Dr. Loretto R. Auvil, 807 Division Street, Parkersburg (Parkersburg Academy). Doctor Auvil, a native of Beaverdam, Virginia, was graduated from Randolph Macon College and received her M. D. degree from the Medical College of Virginia in 1957. She interned at Camden Clark Hospital in Parkersburg, 1957-58, and was licensed to practice in West Virginia in 1959. She is engaged in general practice.

* * * *

Dr. D. Brown Barber, 906-A Walnut Road, Charleston (Kanawha). Doctor Barber was born in Charleston and was graduated from the University of Chicago. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree from the Medical College of Virginia in 1957. He interned at Johnston-Willis Hospital in Richmond, Virginia, 1957-58, and served a two-year residency in general practice at McLaren General Hospital in Flint, Michigan, 1958-60. He served with the United States Navy, 1944-46 and 1951-52.

* * * *

Dr. Thornton A. Beckner, Man Memorial Hospital (Logan). Doctor Beckner, a native of Meiktile, Burma, was graduated from La Sierra College in California and received his M. D. degree from the College of Medical Evangelists in Los Angeles in 1955. He interned at Duval Medical Center, 1955-56, and also served a three-year residency there. He served as an enlisted man with the Armed Forces during World War II and he was previously located in Jacksonville Beach, Florida. His specialty is obstetrics and gynecology.

* * * *

Dr. Narciso Chan, Kanawha Valley Hospital, Charleston (Kanawha). Doctor Chan was born in Solana, Philippines, and was graduated from the University of Sto. Tomas in Manila in 1953. He interned at Sacred Heart Hospital in Spokane, Washington 1953-54, and served a residency at Cabell-Huntington Hospital, 1958-61. His specialty is pathology.

* * * *

Dr. Kenneth L. Clark, 408 Peoples Building, Charleston (Kanawha). Doctor Clark, a native of Charleston, attended the two-year School of Medicine at West Virginia University and received his M. D. degree from the Medical College of Virginia in 1950. He interned at Cincinnati General Hospital, 1950-51, and served residencies at that hospital and at the Medical College of Virginia Hospital. He served as a Captain in the Medical Corps of the United States Air Force, 1955-57, and was previously located at the Baylor University College of Medicine in Houston, Texas. His specialty is internal medicine.

* * * *

Dr. Florine K. Hampton, Peoples Building, Charleston (Kanawha). Doctor Hampton was born at Kermit, West Virginia, and was graduated from West Virginia University. She attended the two-year School of Medicine at the University and received her M. D. degree from the Medical College of Virginia in 1950. She interned at General Hospital in Allentown, Pennsylvania, 1950-51, and was previously located in Portsmouth, Virginia. She is engaged in general practice.

Florida Physician Guest Speaker Before Blood Bank Assn.

Dr. James J. Griffitts of Miami, Florida, was the guest speaker at the first scientific meeting of the West Virginia Association of Blood Banks which was held at Memorial Hospital in Charleston on November 11.

Doctor Griffitts, who is assistant director of the John Elliott (Dade County) Blood Bank in Miami and a past president of the American Association of Blood Banks, presented a paper on "Problems in Blood Banking." A question and answer period followed.

Doctor Griffitts was assisted in the question and answer period by a panel consisting of Mr. Harold Klein, M.T., of Beckley, Dr. Robert A. McDougal of Parkersburg, and Dr. Rex B. Conn, Jr., director of laboratories at the West Virginia University School of Medicine.

The meeting was also sponsored by the West Virginia Association of Pathologists. Dr. David B. Thornburgh of Parkersburg is president of that organization and Doctor McDougal is president of the Blood Bank Association.

New Publication Outlines Studies Of NIH Clinical Center

The Clinical Center of the National Institutes of Health recently published a new revision of "Current Clinical Studies and Patient Referral Procedures." The publication describes briefly the diagnostic requirements, purposes and methods of those studies expected to be most active during the current year.

Consideration for admission to the Clinical Center is restricted to individuals referred by their own physician and, on the basis of a summary provided by referral, judged by the appropriate NIH investigators to have a particular kind and stage of illness or other condition required in one or more clinical studies.

Upon discharge, a full report of Clinical Center findings on his patient is furnished to the referring physician.

Physicians may obtain a copy of the publication by writing to Dr. Jack Masur, Director of the Clinical Center, NIH, Bethesda 14, Maryland.

PG Course on Obstetrics

A discussion of psychosomatic problems of obstetrical practice will be featured in a postgraduate course, "Obstetrical Problems in Private Practice," which will be presented by the Medical College of Georgia in Augusta, January 23-25.

Emphasis will be on the prevention and management of the minor, as well as the major complications in pregnancy, and the course is accepted for 18 hours of credit by the American Academy of General Practice.

Further information may be obtained by writing Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

Chaplain's Services Program At WVU Medical Center

During recent months administrative officials at the West Virginia University Medical Center and a committee of local clergymen in Morgantown have developed plans to establish the position of "Director of Chaplain Services" at University Hospital.

The Reverend Donald L. Rogan, Rector of Trinity Episcopal Church and chairman of the local advisory committee in Morgantown, prepared the following report for publication in *The Journal:*

The University Hospital at the West Virginia University Medical Center in Morgantown is amply equipped with a beautiful Inter-Faith Chapel, but not as yet with any official, organized Chaplain's services.

Plans are currently in progress to establish the position of "Director of Chaplain Services" at the institution, because of the combined interest of the Medical Center administration and the local (town and campus) clergy in Morgantown, together with the encouragement of the West Virginia Council of Churches.

Clinical Training for Clergymen

The desire to have the position established is not surprising in view of the ever-widening appreciation of the importance of religious and pastoral care as a part of overall medical care. It is not unusual today for a minister's education to include what is called "clinical training," in which he has had supervised pastoral counseling of hospital patients and instruction in establishing professional relationships with hospital staffs.

A three-month period of training in an accredited program is often thought to be the minimum to qualify a clergyman to visit patients in hospitals and sick rooms with more than a well-meaning attitude, i.e., with knowledge and understanding of the circumstances of illness.

A professional hospital chaplain, such as is being sought to fill the position at the University when it is established, will have had considerably more than this minimum and will be certified as to his qualifications by national organizations involved in this training, such as the American Protestant Hospital Association.

A Director of Chaplain Services is called for by the sheer size of the Medical Center in Morgantown. There are already upwards of 100 persons on the clinical staff, with 30 interns and residents, and students in basic sciences which will soon number 200 in dentistry, 160 in medicine, 150 in nursing, 160 in pharmacy and 50 in various graduate studies. This does not include the obvious: more than 500 patients which the hospital will eventually accommodate to whom the Chaplain will minister in the following ways:

(1) Representing the patient's own pastor as requested.

(2) Notifying the patient's pastor of patient concerns which may need some follow-up.

(3) Maintaining and using an on-call list of local pastors by denomination.

(4) Maintaining for local pastors a patient list by denomination.

(5) Scheduling inter-faith services of worship in the Hospital Chapel.

Thus, he will be a coordinator of inter-religious activities for a great many groups, the overall size of which precludes effective attention on the part of local, partially-informed clergy.

The Inter-Faith Chapel at the West Virginia University Medical Center is located on the main floor of the University Hospital, readily available to patients, their relatives and friends. Theme of the sculpture at the altar is Isaiah 6:3—"and one cried unto another and said: Holy, holy, holy, is the Lord of hosts; the whole earth is full of his glory."

It might be added for emphasis, regarding patients, that already more than 50 per cent of those admitted are from outside Morgantown and that 8.5 per cent of all patients state no religious preference. It will be seen that spiritual problems in both these groups can routinely be met only by someone with routine access to the situation.

Qualifications and Duties of Director

A committee of the Monongalia County Ministerial Association has been working closely with the Hospital Administrator, with the West Virginia University Foundation and with other University officials. Such agreements as have been worked out assure that the person who is secured as Director of Chaplain Services will be an ordained clergyman with at least nine months of clinical pastoral education, that he will have teaching status in the University Hospital, and that he will begin with adequate support from all possible sources. It is assumed that he will possess the degree of Bachelor of Divinity and a Ph.D. degree in psychology as his academic equipment. His employment will be in the hands of the University upon the nomination of the local committee and with the approval of the state Council of Churches.

Establishing the position will be the result of cooperation among *at least* those religious bodies represented in Morgantown and on the University campus, who have pledged themselves corporately for one-half the cost of the venture for the first several years. The cooperation of other religious bodies will be welcomed. The University will furnish the Chaplain's office and secretarial services and the other half of his total support.

Continuing support from the cooperating denominations and faiths will come in future in the form of scholarships for clinical trainees assigned to the Director of Chaplain Services for their own "chaplain internships," as his program of clinical workshops and conferences for ministers and theological students takes shape, for this, too, will be his responsibility.

The statewide importance of this venture is based on the statewide importance of the University Hospital:

(1) Patients from all over West Virginia under treatment;

(2) Ministers and physicians from all over West Virginia mutually concerned for the patient's welfare while at the University hospital; and

(3) Opportunity for ministers and future ministers from all over West Virginia to benefit from the training and experience of the Director.

Statewide Support Invited

The church groups which have taken the lead in moving toward matching the fine Chapel with a qualified Chaplain by the summer of 1962, warmly invite individual support for the establishment of the position described in this report. It will not be possible for the work at the University Hospital to proceed on the level of spiritual effectiveness which has been suggested without the warm encouragement and support of interested parties throughout the state.

Tax-deductible contributions will be accepted. Checks designated "Director of Chaplain Services" should be made payable to the West Virginia University Foundation, Inc., Morgantown, West Virginia.

J. H. Yeatts Named Executive Director Of State Cancer Society

John H. Yeatts of Raleigh, North Carolina, has been appointed executive director of the West Virginia Division of the American Cancer Society. The appointment was announced late in November by Dr. Robert J. Johnson of Morgantown, president of the organization.

Mr. Yeatts, who succeeded Ralph G. Beveridge, has been serving as consultant to Region 4 of the American Cancer Society. Prior to his employment by the American Cancer Society, he served for seven years as a state representative and director of public information for the National Foundation.

Mr. Yeatts is a native of Meadows of Dan, Virginia, and was graduated from the College of William and Mary.

PG Course on Medical Genetics

A postgraduate course on Medical Genetics, sponsored by the American College of Physicians, will be held at the University of Michigan Medical Center in Ann Arbor, Michigan, January 29-February 1. Dr. James V. Neel will serve as director of the four-day course.

Further information may be obtained by writing the American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania.

Ob. & Gyn. Examinations

The American Board of Obstetrics and Gynecology has announced that Part II examinations, oral and clinical, will be conducted by the Board at the Edgewater Beach Hotel in Chicago, April 9-14.

Further information may be obtained by writing Dr. Robert L. Faulkner, Secretary, American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.

'Mediphone'

"Mediphone," a telephone service that furnishes physicians with vital information necessary to meet therapeutic emergencies, has been organized by a group of physicians in Washington, D. C.

Membership in the organization is available to licensed physicians residing within the limits of the continental United States. Membership is also available to hospitals, medical groups and industrial health facilities. Member physicians have access by means of telephone to all the information available from all sources about any one of the more than 8,000 drugs in use today.

Further information concerning the organization may be obtained by writing Dr. Clifton R. Brooks, Mediphone, Inc., 1500 Massachusetts Avenue, N. W., Washington 5, D. C.

New Health Department Publication Summarizes Current Conditions

Communicable diseases, radiological health and a report on causes of death in West Virginia were among the items featured in a new publication, "State of the State's Health," which was launched early last month as a supplement to the weekly morbidity report of the State Department of Health.

State Health Director N. H. Dyer said that the report is intended as a weekly summary of health conditions for the Governor and people of West Virginia and will offer a non-technical analysis of morbidity and mortality data, together with brief discussions of other health topics of current interest.

A continuing high incidence of infectious hepatitis drew comment from Doctor Dyer, who noted that 1,513 cases had been listed by the week ending December 2, the highest total for any year on record. He forecast that the problem would become "increasingly acute" during the winter and spring months ahead.

Influenza-Like Diseases

Based on advice from the Public Health Service, the health director cautioned against the possibility of a cyclical increase during the winter months of influenza-like diseases. He urged immunization for high-risk groups, including the aged and infirm, persons suffering from chronic diseases and expectant mothers.

"Experience has shown that mortality is highest among these classifications," Doctor Dyer observed. "From 1957 through 1960, West Virginia recorded more than 253,000 cases of influenza-like diseases and 2,920 deaths from pneumonia and influenza."

A temporary shortage of vaccine has delayed immunization efforts, he explained, but health education services of the department will continue to stress to patients in high-risk categories the importance of keeping in touch with physicians so that they may receive the vaccine when available.

Radioactive Fallout

As a means of providing better surveillance and to allay public concern regarding health hazards from radioactive fallout, Doctor Dyer said radiological health programs in the state are being intensified in cooperation with federal agencies. He expressed belief that the move was necessary, especially in view of "lack of precise knowledge on results of increased low-levels of exposure over long periods of time and cumulative effects of radionuclides which are ingested from all sources."

Although higher levels of radioactivity have been found recently in air, water and food, Doctor Dyer said they remain within ranges considered an acceptable risk for a lifetime and that improved procedures for sampling and analyses would provide better data for evaluating the situation.

Diseases of the heart (38.1 per cent), malignant neoplasms (14.3 per cent), and vascular lesions affecting the central nervous system (12 per cent) continued as the leading causes of death in West Virginia during 1960. In an analysis of public health statistics for that year, Doctor Dyer noted that the three causes alone account for nearly two-thirds of all deaths recorded in the state. Other causes: accidents (6 per cent) pneumonia and influenza (4.7 per cent), general arteriosclerosis (2 per cent), diabetes mellitus (1.5 per cent), suicide (1.4 per cent), congenital malformations (1.3 per cent), and nephritis and nephrosis (1 per cent). All other causes accounted for 17.8 per cent of the total.

He said the State Health Department will continue to emphasize the need for regular physical examinations as a means of early detection of diseases and more effective programs aimed at control.

Seminar on 'The Adolescent' Planned in Morgantown

A seminar on "The Adolescent" will be held in the auditorium at the West Virginia University Medical Center in Morgantown, June 28-29. The conference will be the third in a series of seminars on growth and development co-sponsored by the Division of Maternal and Child Health of the State Department of Health, and the Division of Crippled Children's Services of the West Virginia Department of Welfare.

It is anticipated that the seminar will explore some of the problems of the present-day adolescent as they affect him and his family and his community.

Additional information concerning the program will appear in future issues of *The Journal.*

Thoracic Society Meeting in Miami Beach

Clinical and laboratory work in tuberculosis and other respiratory diseases will be discussed in three days of scientific sessions at the annual meeting of the American Thoracic Society, medical section of the National Tuberculosis Association, in Miami Beach, Florida, May 21-23.

The feature of the meeting will be symposia on "How Effective Can Anti-Tuberculosis Therapy Be?" and "Chronic Bronchitis—An Entity?" Round-table discussions will be held during afternoons of the three-day meeting.

Further information may be obtained by writing the American Thoracic Society, 1790 Broadway, New York 19, N. Y.

PG Course in Chicago

A postgraduate course in laryngology and bronchoesophagology will be presented by the Department of Otolaryngology at the University of Illinois College of Medicine in Chicago, April 2-14.

Registration will be limited to fifteen physicians who will receive instruction by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Additional information may be obtained by writing the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Dr. William C. Menninger To Speak At Mental Health Dinner

Dr. William C. Menninger will be the speaker at the Third Annual Mental Health Dinner which will be held at the Daniel Boone Hotel in Charleston on January 17. The dinner will be co-sponsored by the West Virginia Association for Mental Health and the American Legion.

Doctor Menninger, who is president of the Menninger Foundation in Topeka, Kansas, will discuss "Mental Health—Everybody's Business."

Earlier that same day Doctor Menninger will address a joint session of the State Senate and House of Delegates. He has appeared before the legislatures of nineteen states in behalf of local efforts in improving the treatment of mental illness.

Doctor Menninger received his M.D. degree from the Cornell University Medical College in 1925 and has served as President of the American Psychiatric Association, American Psychoanalytic Association and the Group for the Advancement of Psychiatry.

During World War II, he served as consultant in psychiatry to the Surgeon General of the Army holding the rank of Brigadier General. He was awarded the Distinguished Service Medal and the French Legion of Honor.

In addition, Doctor Menninger has been the recipient of the Lasker Award, the United States Chamber of Commerce Award for "Great Living Americans," and the American Education Award from the Associated Exhibitors of the National Education Association.

State physicians have been extended a cordial invitation to attend the dinner meeting. Tickets are $4.50. Requests for reservations should be mailed to Miss Alice Scott Leslie, Executive Director, West Virginia Association for Mental Health, 226½ Capitol Street, Charleston 1, W. Va.

Allergy Course in Pittsburgh

A seven-day course in allergy, sponsored by the Section on Allergy of the Montefiore Hospital in Pittsburgh, will be presented at that hospital, May 20-26.

The course is designed to orient the internist and general physician in the various phases of allergic diseases. Several distinguished physicians will present lectures and reports, as well as laboratory demonstrations.

The registration fee is $85. Further information may be obtained by writing Dr. Leo H. Criep, Bigelow Apartments, Pittsburgh, Pennsylvania.

PG Conference in Charlottesville

A postgraduate conference on selected topics in internal medicine will be held at the University of Virginia School of Medicine in Charlottesville, March 2-3. Registration fee for the two-day meeting is $15.

Further information may be obtained by writing Mrs. Anne Kavanaugh, Secretary, University of Virginia Hospital, Box 329, Charlottesville, Virginia.

Dr. Marshall Glenn New Member Of 'Sports Hall of Fame'

Dr. Marshall Glenn of Charles Town, an all-time West Virginia University athletic star in football and basketball, is the newest member of the West Virginia Sports Hall of Fame.

Doctor Glenn, who won election in the Hall's old-timer category, consisting of candidates who won their fame more than twenty-five years ago, was inducted into the Hall of Fame during the 17th Annual Victory Awards Dinner in Wheeling on December 4.

A native of Elkins, West Virginia, and known as "Little Sleepy" during his undergraduate days at the University, he was a halfback on the 1927-29 football teams. He also starred as a member of the basketball

Dr. Marshall "Little Sleepy" Glenn of Charles Town was inducted into the West Virginia Sports Hall of Fame during the annual Victory Awards Dinner in Wheeling on December 4.

team and for several years held the high jump record at the University.

Following graduation from the University, he coached two years at Martinsburg High School and returned to the University in 1934 as basketball coach. The next year he took over as freshman football coach and in 1937 was appointed head football coach. In his first season as head coach he directed the University team to a 8-1-1 record, including the Sun Bowl championship.

Doctor Glenn relinquished his coaching duties shortly thereafter to devote full time to his medical studies. He received his M.D. degree in 1938 from the Rush Medical College in Chicago, and interned at Harper Hospital in Detroit, Michigan, 1938-40. He was licensed to practice in West Virginia in 1940 and located at Charles Town where he has engaged in general practice continuously since that time. He served as a flight surgeon with the Medical Corps of the United States

Navy during World War II, being released in 1945 with the rank of Lieutenant.

He is a member of the Eastern Panhandle Medical Society, the West Virginia State Medical Association and American Medical Association.

Doctor Glenn has maintained an active interest in sports and is considered one of the top amateur golfers in the Eastern Panhandle.

AMA Conference on Mental Health In Chicago, February 2-3

The Eighth Annual Conference of Mental Health Representatives of State Medical Associations will be held at the Drake Hotel in Chicago, February 2-3. Theme of the meeting will be "Implementation of the American Medical Association's Program on Mental Illness and Health."

Dr. Leo H. Bartemeier of Baltimore, Maryland, Chairman of the AMA Council on Mental Health, said the program will be devoted to a discussion of the proceedings of the preliminary program conference held last September, together with formulation of plans for the first AMA National Congress on Mental Health which will be held next October.

Further information may be obtained by writitng to the AMA Council on Mental Health, 535 North Dearborn Street, Chicago 10, Illinois.

Four Physicians To Participate In Television Series

Four Huntington physicians will participate in two television programs which will be presented by WSAZ-TV, in Huntington, during the month of January. The programs are part of a series which was inaugurated in September to acquaint the public with the latest advances in medicine and surgery.

The programs are produced by WSAZ-TV in cooperation with the Cabell County Medical Society. Entitled "Conference—Your Doctor Speaks," the program is televised on alternate Sundays from 5:00 to 5:30 P. M.

Drs. J. Foster Carr and William J. Kopp will appear on the January 14 program which will be in the nature of a concise appraisal of protective and emergency measures for "Accidental Poisoning."

On January 28, Drs. M. G. Stemmermann and M. Bruce Martin will participate in a program devoted to "The Retarded Child." Other participants will include an educator and a minister.

Seminar on Arthritis and Rheumatism

A Seminar on Arthritis and Rheumatism will be held at the Hotel Roanoke in Roanoke, Virginia, April 14-15. The two-day seminar will be sponsored by the Virginia Chapter of the Arthritis and Rheumatism Foundation and the local chapter in Roanoke.

Additional information may be obtained by writing Mr. John A. Rudd, Executive Director, Virginia Chapter of the Arthritis and Rheumatism Foundation, P. O. Box 1004, Lynchburg, Virginia.

Four Physicians To Present Papers At Oph. and Otol. Meeting

Four prominent physicians have accepted invitations to present papers at the Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology which will be held at The Greenbrier in White Sulphur Springs, April 23-25.

Dr. Albert C. Esposito of Huntington, the president, said that Drs. Ramon Castroviejo of New York City and Frank D. Costenbader of Washington, D. C. will present papers on ophthalmology.

Drs. Kelvin A. Casper of Philadelphia and Fred R. Guilford of Houston will speak on subjects in the specialty of otorhinolaryngology.

Doctor Esposito also said that Mr. Philip Salvatori of Obrig Laboratories will appear on the program to discuss the proper techniques of fitting contact lens.

Registration fee for the three-day meeting will be $25. Additional information may be obtained by writing the Secretary, Dr. Worthy W. McKinney, 100 E. Main Street, Beckley, W. Va.

Huntington Bureau Receives Citation

The Physicians and Dentists Bureau of Huntington recently received a citation from the President's Committee on Employment of the Handicapped for service in hiring handicapped individuals. The award was accepted by Hal and Truly Herbert, owners of the Bureau.

The citation was awarded for "Exceptional Contributions in Furtherance of Employment of the Handicapped." The Bureau has 15 employees, six of whom are handicapped.

Ophthalmology Section Accepting Papers

The Section on Ophthalmology and Otolaryngology of the Southern Medical Association is now accepting papers to be considered for presentation before the annual meeting in Miami Beach, Florida, November 12-15, 1962. The deadline for submitting papers is May 15.

Further information may be obtained by writing the secretary, Dr. Albert C. Esposito, 1212 First Huntington National Bank Building, Huntington 1, West Virginia.

PG Course on Pulmonary Function

The American Thoracic Society has announced that a postgraduate course on "The Measurement of Pulmonary Function in Health and Disease" will be presented at the Boston City Hospital in that city, March 26-30, 1962.

The course is designed for physicians interested in diseases of the chest who wish to acquaint themselves with the methods used in the evaluation of pulmonary function. The methods used in the evaluation of pulmonary function will be demonstrated.

Further information concerning the course may be obtained by writing Dr. Edward J. Welch, 1101 Beacon Street, Brookline, 46, Massachusetts.

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Delivery is for the Baby*

Thaddeus L. Montgomery, M. D.

This is an age of slogans—"Africa for the Africans," "Cuba for the Cubans," "South America for the South Americans." The assumption is that the local residents possess the scene and that the colonists, the invaders, the poachers and the various other extraneously interested persons gradually will be thrust aside or driven out. Whether this is entirely correct in the instance of provincial and international relations is a question. The general principle of squatters' rights, however, seems to be upheld by popular usage.

The particular key words were selected because they epitomize today's major concern in obstetric delivery. For instance, there could be no pregnancy nor delivery if there were not a baby in the making. Second, while other persons undoubtedly are to be considered in the process of reproduction, notably, the mother and, secondarily, the father, there is, nevertheless, no single person so much affected by or involved in the intricate physiologic processes of birth as the baby. Third, since attention has been given to maternal interest over the years and the care and safety of the mother have been provided for with some thoroughness, time now permits of turning additional attention to the baby. If we are to produce a finer generation of youth, greater care must be devoted to selection and training of parents, control of reproduction, and the assuring that each new individual is delivered into this difficult world unimpaired in vitality and endowed with clear qualities of mind and spirit.

Obstetric Strategy and Tactics

More than anyone else, the obstetrician plays a preeminent role in assuring that the newborn has an adequate and unhandicapped start in its difficult extrauterine existence. Strategy which the obstetrician employs in the supervision of pregnancy, and his tactics in labor and delivery may spell the difference between a successful, happy and contributing life and an impaired, restricted, dependent existence. Actually, the problem of insuring fetal vitality and neonatal health is the most important single issue in the field of obstetrics today, and more time, money and thought are being devoted to research in this field than in any other.

The subject has been a matter of concern to me since I began the practice of obstetrics in 1922, not to mention a pedagogic career in 1925. Most of the research I have done has been in the interests of the fetus and the newborn. In view of this fact, I am today going to look back over these previous studies and publications in an effort to re-evaluate them in the light of present day medical investigation and practice and determine which should be discarded and which still may be approved and continued in use. I feel that such retro-reviewing from time to time is important.

Review of Previous Studies

My first major research paper was a thesis for the American Association of Obstetricians and Gynecologists, in 1930, with the title, "The Etiology and Significance of Necrosis of the Placenta."[1] It had to do with the histologic study

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*Presented before the third general scientific session of the 94th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26, 1961.

Submitted to the Publication Committee, August 26, 1961.

of focal necrosis and infarction of the placenta, their biologic origin and significance, and the part they played in fetal impairment and fetal demise. It was pointed out that small areas of focal necrosis in connection with the chorionic villi oftentimes constituted evidence of aging and frequently marked the site where villi ruptured and fetal blood escaped into the intervillous space. Adjacent villi became matted together by the necrotic process, and larger and larger segments of the placenta gradually were thrown out of commission. In addition, there were other types of infarction which were related to small or extensive areas of separation of the placenta and retroplacental bleeding.

The initial effort in the field of placental pathology was followed by a study of the inflammatory lesions of the placenta, from which it was found that 10 per cent of all delivered secundines revealed some evidence of inflammatory reaction. Where the membranes had been ruptured for some time, the inflammatory reaction extended from the membranes into the fetal vessels of the placenta and from thence to the umbilical vein and to the fetus itself. Fetal death, after delivery, from blood stream infection or pneumonitis was therefore related to infections which were acquired in utero. A third paper was devoted to the subject of premature separation of the placenta and its effect on placental tissue and fetal life.[2] A fourth had to do with the vascular lesions of the placenta found in syphilis and other inflammatory and degenerative diseases.

In due course, the author, like many another young obstetrician and gynecologist in Philadelphia, fell under the influence of Dr. Philip Williams and became a member of the Maternal Mortality Committee of Philadelphia and, subsequently, a chairman of the Fetal Mortality Committee. From the findings of the Maternal Mortality Committee the author[3] prepared a major paper in May, 1937, with the title, "Obstetric Amnesia, Analgesia and Anesthesia: Their Relationship to Sudden Death in Labor," which was published in the *Journal of the American Medical Association*. The presentation consisted of an analysis of cases in which sudden death occurred during the intrapartum stages of pregnancy and was related to the choice of amnesic, analgesic, or anesthetic drugs for delivery. At that time there was a wave of enthusiasm for the barbiturates and spinal anesthesia in delivery. The author aimed particular criticism at the deep use of barbituric acid derivatives which depressed the respiratory vitality both of the mother and baby and resulted in a number of deaths. Also, he analyzed the deaths ascribable to poor selection and poor supervision of spinal anesthesia.

In 1938, the author participated in a symposium arranged by the above mentioned Doctor Williams, of the Philadelphia County Medical Society, and chose the subject, "Acrobatic Obstetrics," revealing the fetal deaths and the maternal morbidity and mortality which had followed the use of internal podalic version, high forceps and indiscriminately applied cesarean section, in Philadelphia. At that time, there was a small group of obstetricians following the leadership of Irving Potter in the employment of internal podalic version and boasting that in their respective institutions they never permitted the woman to deliver spontaneously if they could get to her first with forceps or some other operative manipulation. In the fall of 1939, in this room in which we now hold session I discussed a paper which derived from Buffalo, on the technique of internal podalic version and extraction and I called for an evaluation of the maternal morbidity and fetal mortality associated with this operation rather than propaganda for its continuation in obstetric procedure.[4] The discussion lost for me a few acquaintances and made some enemies; it cemented friendship, however, among those members of the profession who were interested in a conservative and sound approach to obstetric practice.

In 1940, I presented as a thesis paper before the American Gynecologic Society the results of investigations of the Fetal Mortality Committee of Philadelphia and classified the iatrogenic as well as the nonpreventable sources of fetal mortality. At that time it was noted that a more careful selection of conservative obstetric procedures and analgesic and anesthetic agents could reduce the perinatal mortality by at least 50 per cent.

Spinal Anesthesia Appraised

In 1944, during the course of my Chairmanship of the Department of Obstetrics and Gynecology at the Temple University School of Medicine, a series of cases was presented, comparing spinal and caudal anesthesia with that of more generally accepted methods, and the conclusion reached was that spinal anesthesia from the standpoint of fetal interest was undesirable in routine vaginal delivery. It proved to be a more extensive anesthetic than was necessary, generally depressed blood pressure by 10 to 20 points and often gave rise to a 2-minute or 3-minute period of hypertonicity of the uterus which, with the hypotensive effect, resulted in hypoxia of the newborn.[5] It was at that time that I personally abandoned its use in vaginal delivery.

Upon my return to Jefferson, in 1946, as Professor of Obstetrics and Gynecology, I became

concerned about the frequent epidemics of gastroenteritis, impetigo and respiratory infection in crowded private and ward nurseries. At that time we instituted rooming-in, making it compulsory on the ward service and selective on the semi-private and private services. In the ward area the baby was placed with the mother within a few hours after delivery and was left with her both day and night. The mother participated to a major degree in the care of her baby and nursed it on a liberal schedule. The care which the individual baby received was enhanced one hundredfold. On the private service, the rooming-in was optional and the baby either spent the entire time or only the daytime with the mother. Some mothers eschewed the idea and continued with the central nursery plan of care.

Rooming-in on this basis continues in our hospital to the present day and has completely rid the ward of all contagious diseases of the newborn. We found also that rooming-in enhanced the mother-baby relationship, encouraged breast nursing, and improved the care which the newborn received in the hospital. This initial approach to a more physiologic handling led to the development of our expanded program of physiologic obstetrics in which classes were given in natural childbirth, labor conducted with minimal analgesia and anesthesia, husbands permitted to be present during labor and delivery, the baby nursed at the breast immediately after delivering, and other physiologic procedures formulated which will be commented upon in subsequent paragraphs. A number of papers were written on the subject of rooming-in, and included descriptions of technical procedures and results.[6]

With the advent of a research laboratory in the Department of Obstetrics and Gynecology, the author[7] instituted studies of the oxygen saturation of the newborn in various types of vaginal delivery and cesarean section, pointing out the delay in oxygenation of the newborn which characterizes even the elective cesarean section and which reached alarming proportions in some complicated sections.

Bacteriology of the Umbilical Cord

With the employment of a full time microbiologist, it was possible to study the bacteriology of the newborn and the effect which hospital environment had on bacterial flora. Bernstine and Ludmir[8] in our department devoted particular attention to the important problem of bacteriology of the umbilical cord. They demonstrated the advantages of nonligation of the umbilical cord, or delayed ligation, over immediate clamping and tying.

A group then made a comparative study of the colonization of babies and mothers in the rooming-in service and in the traditional central nursery service, demonstrating that complete rooming-in and early discharge from the hospital cut significantly the colonization of the newborn with hospital staphylococci.[9]

This and other bacteriologic study of the birth canal in premature rupture of the membranes led to a full dress review of the problems of infection in the newborn which was presented before the Central Association of Obstetricians and Gynecologists, in 1960, under the title, "The Microcosmos and Man." In it suggestions were made concerning reduction of bacteria in the environment of hospitals, revision of hospital architecture designed to reduce bacterial flora, special procedures of management of the newborn, and the treatment of intrauterine infection associated with premature rupture of the membranes.

Over a period of years the author has been concerned by the apparently limited value which some medical consultants, particularly psychiatrists, place on the life of the fetus in utero in certain complications. A protest against such a point of view was embodied in a paper, "The Unstatisticized Obstetric Patient,"[11] which was presented before the Southern Medical Association, in 1958, covering a group of some five patients in whose cases interruption of pregnancy had been advised or suggested but conservative procedures permitted carrying the pregnancy successfully to term and preserved the happy relationship between mother and newborn. These same thoughts have been embodied in a consultation report recently written for the *American Journal of Obstetrics and Gynecology*.[12]

Finally, as a result of these successive efforts in the area of fetal interest, the essayist has spoken out on at least two occasions in behalf of conservative obstetrics. First in his presidential address before the American Association of Obstetricians and Gynecologists, titled "Conservative Obstetrics in a Modern World"[13] and, second, in a paper presented before the South Atlantic Gynecologic Association, with the title "Physiologic Considerations in Labor and the Puerperium."[14] In these two papers a wide spectrum of obstetric procedures was covered: the induction of labor, operative obstetrics, positions for delivery, the physiologic relationship of the baby, cord and placenta, relationship of the mother and baby following delivery, and protection of the baby and mother from hospital infection.

In the presidential address, the author particularly endeavored to support the practitioner in

the field who was trying to do the best in obstetrics of which he was capable, sometimes in trying and difficult circumstances. To these physicians he directed the following words:

"If you consider that birth of the baby is the most important single event of the day and adjust your practice to provide the necessary attention and support to your patient,

"If you employ sedation and anesthesia judiciously,

"If you are alive to the possibilities of complications and are prompt in correction,

"If you are conservative in the induction of labor and tubal ligation,

"If you encourage mothers to nurse their babies and to participate in baby care,

"If you are thinking not only of the exigencies of the moment but of the effects of the future,

"If you are helping young couples to establish the family and the home,

"Then, in the opinion of the speaker, you are practicing not archaic or old fashioned obstetrics, but are giving the finest service that any one person can give to another at the most important time in that person's life."

Factors of Paramount Importance Today

As I look back over this lifetime of interest and concern about the physiologic in labor and the preservation of fetal interest, I have no feeling of reprehension and I think we can pick out and briefly dwell upon some of the considerations which still are of paramount importance in present day obstetric practice.

Induction of Labor.—The strong feeling which I originally had regarding induction of labor for convenience of the patient and obstetrician has been somewhat assuaged by the carefully controlled studies of Caldeyro-Barcia.[15] Pitocin or Syntocinon induction with avoidance of rupture of the membranes, carefully observed, is receiving more and more acceptance and usage in American obstetric practice.

Complications can occur, however, and do occur, and there are several questions regarding the procedure that have not been answered. For instance can a definitely prescribed type of labor be successfully and safely imposed on all uterine pregnancies? May there not be a difference in the enervation, muscular activity, metabolism of the uterus, uterine circulation and oxygenation, which makes for one individual a slower labor and for another a rapid type of delivery? I suspect as we learn more about the physiology of uterine contractions and uterine behavior we will come to the opinion that some women have the type of labor they do because of the type of uterine muscles they possess and that this individual peculiarity of labor cannot be too successfully or safely interfered with.

Therefore I still am of the opinion that most labors should be allowed to start themselves if they do so within a reasonable time with relationship to date of expectancy and size of fetus. The obstetrician, practicing in groups, may adapt his time to the vagaries of obstetric labor and delivery rather than try to adjust labor and delivery to his individual convenience.

In the meantime, induction of labor and stimulus of labor play an important part in certain conditions such as toxemia in pregnancy, hypertensive disease, and true uterine inertia.

Analgesia and Anesthesia.—The general interest which has arisen in perinatal mortality, the studies of E. Stewart Taylor, Nicholson Eastman and others, and the interest of the laity in natural childbirth have given rise to a policy of conservatism today in the use of amnesic and analgesic drugs, at least in comparison with the situation some 20 to 25 years ago. Regional and local forms of anesthesia have replaced systemic anesthesia, and depression of fetal respiration of a severe type is now rare.

In our own practice we find that the prenatal classes which are held for the mother provide important foreknowledge which gives the parturient increased confidence and encourages better cooperation, that the presence of the husband during labor and the frequent visits of the obstetrician render support which makes it possible to reduce agents to control fear and pain. Relaxants and analgesia are given in small dosage, spontaneous delivery is conducted under light mixtures of nitrous oxide and oxygen and pudendal block or perineal infiltration is employed for episiotomy and repair. In these circumstances the newborn resuscitates promptly at birth, the mother is awake in a few moments, and the handling of the important third stage of labor can be done efficiently and without any complicating problems.

Anesthesia for cesarean section still is a problem and is one of the most important considerations in planning and providing for this operation.[16] For complications such as severe toxemia in pregnancy, placenta previa and premature separation we employ local anesthesia or abdominal field block. For elective and repeat cesarean sections we general resort to continuous or single shot spinal anesthesia, taking particular caution to first establish intravenous fluid, administer a

vasotensive drug, and tilt the table laterally 15 degrees toward the operator, displacing the uterus from the vena cava. These procedures help to eliminate hypotensive reactions.

Operative Delivery.—Statistics drawn on from private practice over a period of 10 years speak pretty clearly regarding our ideas of operative delivery (Table 1). Eighty per cent of deliveries are spontaneous. We can still see nothing too wrong with natural physiologic delivery when all is proceeding well with mother and child and the labor is progressing nicely. Approximately 118, or 10 per cent of spontaneous deliveries were conducted in the lateral position, either because of orthopedic problems or the natural inclination of the mother to this comfortable attitude in labor. Low forceps was performed in 12 per cent of cases where the procedure was indicated for one reason or another. Breech delivery accounted for approximately 3 per cent, there were no internal podalic versions, and cesarean section was performed in 5.5 per cent of cases.

Table I

Statistics of Delivery from Private Group Practice

	Montgomery-Bowers (1949-1960)	
Viable births (1,000 Gm. and over)	1,432	
Type of Delivery		
Spontaneous vertex	1,138	(79.5%)
Forceps—low	170	(11.8%)
Forceps—Mid	3	(0.2%)
Breech	41	(2.8%)
Internal version	0	
Cesarean section	79	(5.5%)
Lateral position	118	(9.0%)
Maternal Mortality	0	
Fetal Mortality (1,000 Gm. and over)		
Fetal deaths	28	(19 per 1,000 births)
Neonatal deaths	11	(7 per 1,000 live births)

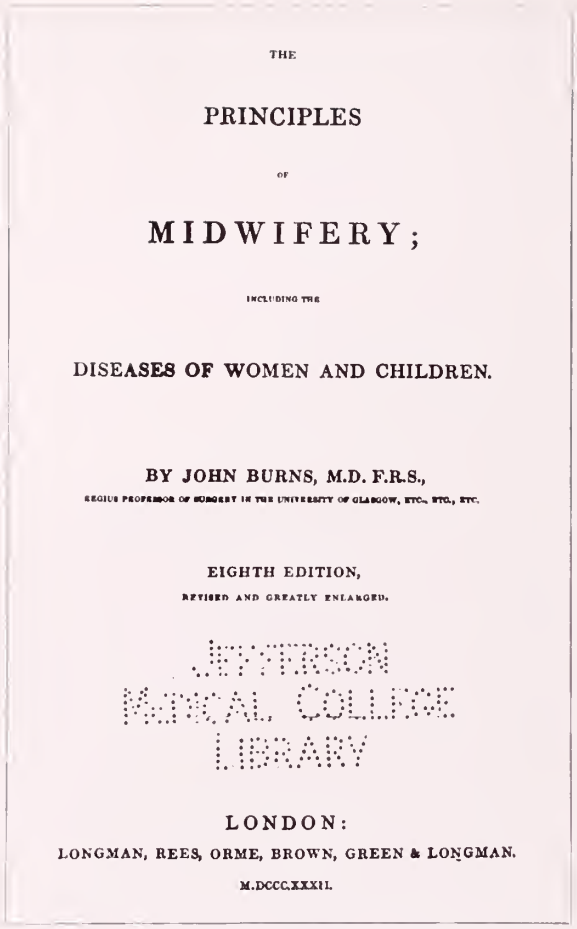
Unquestionably the frequency of cesarean section is creeping up as new indications for the operation appear in breech presentation, inertia uteri which does not respond well to pitocin stimulation, and midpelvic arrest where midforceps are used before. If one also accords to the philosophy of repeat cesarean section, and if one permits in a given patient three or more successive cesarean sections, the frequency of cesarean section rate may well rise to higher levels. It is impossible to evaluate the efficiency of an obstetric service on the basis of low cesarean section rate alone.

Physiologic Relations at Birth of Baby, Cord and Placenta.—Reference has been made in previous contributions to the physiology of the umbilical cord and its management at birth. It is our practice to keep the fetus on an inclined table about 6 inches below the placenta in utero and the cord undisturbed until the placenta has been completely separated and delivered. The placental basin is then placed some 6 inches above the level of the fetus on an inclined table and allowed to remain until all pulsation in the cord has ceased. By this time all fetal blood has come over from the placenta to the fetus providing a reservoir of intravascular fluid during the important re-routing of fetal circulation. At the end of this period the cord veins and arteries are collapsed and the umbilical cord becomes a soft white ribbon which is readily ligated without risk of trapping blood.

The cord, in these circumstances, desiccates promptly and provides less substance for bacterial implantation and growth. Subsequent care consists of washing with alcohol, painting with an antiseptic tincture, and application of an elastic ligature ¼ or ½ inch from the cutaneous junction. The redundant cord is then cut away.[17] The plan is modified in some degree in the presence of an Rh. negative baby where it is expedient to secure a specimen of blood for Rh. determination, Coombs reaction and serum bilirubin level. In these circumstances, a 10 cc. specimen of blood is drawn from the umbilical vein with a sterile needle and syringe immediately after the birth of the fetus. When the cord pulsation has ceased, an elastic ligature is placed 2 inches from the umbilicus to provide space for an exchange transfusion if such becomes necessary.

Points in the Immediate Care of the Newborn in the Delivery Room.—At one time not too far back in medical history, obstetrics was taught by a Professor of Midwifery and Diseases of Children (Figure 1). This old arrangement recognized the close relationship which lies between delivery and the care of the newborn, gave opportunity for the obstetrician to observe the effect of the procedures which he employed, and kept constantly before him the important relationship of the mother and child. In the face of such activities the physician became truly a family-related person who was looked upon with such respect, not only by the parturient, but by her family and her children.

Time, scientific progress, expansion of knowledge in each of many fields, and development of pediatrics as an individual specialty have changed much of this custom, and in the majority of hospitals today the newborn is placed in nurseries under the care of the pediatrician. The obstetrician, however, cannot divest himself of the immediate handling and the immediate re-



THE

PRINCIPLES

OF

MIDWIFERY;

INCLUDING THE

DISEASES OF WOMEN AND CHILDREN.

BY JOHN BURNS, M.D. F.R.S.,

REGIUS PROFESSOR OF SURGERY IN THE UNIVERSITY OF GLASGOW, ETC., ETC., ETC.

EIGHTH EDITION,

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M.DCCC.XXXII.

Figure 1. The Principles of Midwifery; Including the Diseases of Women and Children.

sponsibility of the baby at delivery. The medication which he has given the mother, the measures which he has employed for delivery, the manipulation of the baby as it is discharged from the birth tract, the importance of instantaneous evaluation and treatment of the baby make it inevitable that he retain and fulfill these responsibilities.

Also it is important that he maintain an interest in what goes on in the newborn nursery and the general philosophy of newborn care. He must participate also in the studies of perinatal morbidity and mortality in the hospitals in which he practices. It is of particular importance that he plan ahead for the care of the baby in each complicated situation such as prematurity, toxemia of pregnancy, antepartum hemorrhage, breech extraction and cesarean section.

If the baby does not respond well to the simple resuscitative procedures of aspiration and administration of oxygen, a competent person must be present to perform exposure of the larynx and catheterization of the trachea. Usually the person best trained in this field is the anesthetist, who frequently has to perform such manipulations in the adult and the child. The Apgar evaluation of the newborn performed one minute after delivery is a good criterion of how the baby should be handled, except that one should not wait this length of time in a gray, limp, apneic newborn.

The administration of oxytocic drugs, notably ergotrate or methergin, should be held until the placenta is obviously separated and coming down into the vagina and then given intramuscularly unless there is some extraordinary reason for its intravenous administration. While this method is attended with somewhat greater bleeding during the third stage of labor, we believe that it guards against certain ill effects of earlier administration, notably:

1. The hypertensive effect which an intravenously administered oxytocic has upon the mother,

2. The possibility of trapping a second baby in the instance of unrecognized multiple pregnancy,

3. The profound squeezing effect which the rapid expulsion and separation of the placenta has upon forcing fetal blood in large quantities over into the fetal circulation.

As has been stated, the umbilical cord is allowed to remain intact until the placenta is delivered and need not be ligated until 15, 20, or 30 minutes after delivery of the fetus and placenta. We believe this is important in preserving the physiology of the newborn and in preventing infections of the umbilical cord.

When the delivery is completed the obstetrician has an important obligation and that is to make an examination of the newborn that is sufficiently extensive to bring to light congenital abnormalities, inadequate respiration, poor oxygenation, or other disturbances which may adversely affect the baby before it reaches the nursery and comes under the care of the pediatrician. The examination should be made in the delivery room before the operator removes his gown, gloves, cap and mask.

In those instances in which the mother intends to nurse the baby, the breasts are prepared and the baby is placed at the breast in the operating room. Thus the mother has a chance to admire and fondle her newborn, the baby is acquainted immediately with the sources of nutrition in which it is interested, and further uterine contractions are stimulated. It is a sensible recogni-

tion of the usual happenstances in all mammalian births. For the husband and wife who may be present together in the delivery room, this viewing of the baby is the culminating moment of their nine or ten months waiting through pregnancy and labor.[18]

Subsequent Care of the Newborn: Rooming-in or Central Nursery Care.—Failure to provide appropriate safeguards for the newborn constitutes one of the greatest condemnations of modern hospital practice. The newborn baby merits the same standards of recovery care as the mother and the same standards of isolation to prevent infection. In the accompanying diagram (Figure 2) I have indicated what I believe are the essential stages in the care of mother and baby following delivery if appropriate safeguards against hemorrhage, shock, and infection are attended to. Adjacent to the labor and delivery room there should be a recovery room for mothers with sufficient bed area where the patient can be kept for 4 to 6 hours, and a recovery room for the newly born infant where the latter may be observed for a similar period of time. Under normal conditions these two areas may be staffed by the same nurse or nurses.

At the conclusion of this period, assuming that the mother displays no evidence of hemorrhage, is reacting nicely, and the baby's respiratory and circulatory responses are satisfactory, mother and baby may be removed to an area which provides either for rooming-in of mother and baby in private rooms or for a small peripheral nursery in intimate relationship to semiprivate rooms. As soon as it can be demonstrated that the mother and baby are reacting nicely from labor and delivery and are proceeding normally with the puerperium, they should be discharged from the hospital. This time may vary in the individual case from 24 hours to 2 or 3 days. Of course, the premature baby or the potentially ill baby will have to be kept longer, and the mother with cesarean section will have to be kept a few days longer.

In the absence of facilities as mentioned above the best arrangement is a simple rooming-in program for mother and baby carried to as complete a degree as the obstetric patient will tolerate.

Our own experience has demonstrated the most effective way of preventing colonization of babies with significant bacteria is by placing them immediately with their mother and discharging them from the institution 24 to 48 hours after delivery. Epidemiologists have pointed out over and over again the most effective way of arresting an epidemic of serious infection is to place the newborn baby immediately with its mother in a separate room.

Control of Infection in Maternities.—Not only must the obstetrician be interested in the problems of immediate labor and delivery, he must devote a certain portion of his time and attention to the common problems of hospital infections and how they affect environment of the maternity patient and the newborn.

As a member of the Infectious Disease Committee of our own institution I instituted a survey of various factors of significance in our own hospital. This led to the paper, "The Microcosmos and Man." I started about the hospital with a camera, recording a number of situations. Boxes, bails and buckets were found on floors where they were rarely moved for cleaning. Suction and oxygen tubes dangled in dirt. Shoes which would not be taken on a camping trip were worn in the delivery room.

While the ventilating system in the new pavilion did not introduce bacteria, it kept dust in constant circuit, picking it up from the floor and

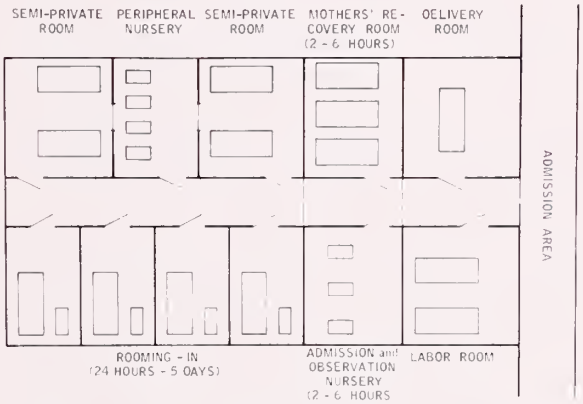

Figure 2. Diagram of successive stage of care of the newborn and parturient (courtesy of The C. V. Mosby Company. Montgomery, T. L.: The Microcosmos and Man, Am. J. Obst. & Gynec. 81:890-901 (May) 1961).

depositing it on the walls, ceilings, patients, newborn babies and instrument tables (Figure 3). The special problem in our own pavilion was the rough acoustical plastered ceiling of asbestos from which stalactites of lint and bacteria dangled and periodically fragmented. These ceilings could never be adequately cleaned and became an ever increasing menace to aseptic technique.

As a result of this visual evidence of faulty construction and practice, also in the face of mounting wound infections and increasing neonatal morbidity, remedial measures were taken. Pedestals were provided for tubing, and supplies were stored in cabinets. Facilities for cleaning

shoes were set up and antiseptic foot mats were placed in strategic areas. Ceilings were coated with plastic or replaced with smooth plaster and floors were regularly sprayed with an iodine solution during operations and deliveries to trap dust and destroy fellow bacterial travellers.

With these measures and other improvements in aseptic technique, wound infection has been kept below 1 per cent on the obstetric and gynecologic service and infant morbidity reduced to a minimum. With it all, the problem of sanitation and housekeeping in large institutions is very

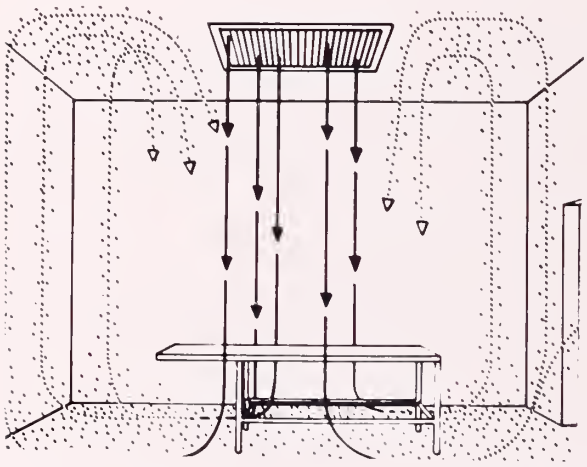

Figure 3. Circuit of dust in air-ventilated operating and delivery room (courtesy of The C. V. Mosby Company, Montgomery, T. L.: The Microcosmos and Man, *ibid*).

great. The presence of a full time sanitary engineer or consulting public health officer would be helpful. Hospital construction of the future should be such also that as each room is emptied it can be entered by an attendant and hosed down from ceiling to floor and all dust and bacteria washed out through a drain (Figure 4).

Years ago, before the golden age of antibiotics when aseptic technique and prompt isolation of infections were standard procedures, a Chicago obstetrician, Joseph B. de Lee strongly advocated that all maternity patients either be delivered in their homes or in a separate maternity hospital (Figure 5). With the admission of infections in pelvic cancer to the women's departments in general hospitals, the sanctity of the maternal hospital unfortunately has been lost. We need to return to the principle of the separate institution, connected only by passages that will make consultations ready and laboratory services available.

Many of the bacterial problems in relation to fetal morbidity and mortality are as yet unsolved and possibly may be always with us because of the indigenous nature of bacterial growth even though the hygienic surroundings of the hospital reach perfection. For instance, the problem of management in ruptured membranes in the immature nonviable fetus is very great. The question of whether or not to administer antibiotics is a moot one and one that is much discussed. In our own service we run cultures in all cases of premature rupture of the membranes and administer antibiotics only if a pathogenic organism of significance is found in the cervix and vaginal canal. Tetracycline or sulfones may be started and a shift then made to the appropriate antibiotic according to sensitivity tests. If the culture reveals simply organisms of low pathogenicity no antibiotics or sulfones are administered. The matter is under further investigation.

Summary

In the conviction that the baby is, after all, the primary concern of pregnancy and obstetric delivery, the author has reviewed a lifetime of work devoted to the enhancement of fetal and neonatal interests in human reproduction.

What is considered best for the baby in utero rather than for the convenience of the mother or the convenience of the obstetrician is a major consideration.

Preliminary education of the mother, cooperation in the physiologic processes of labor, and intimate supervision of labor and delivery are

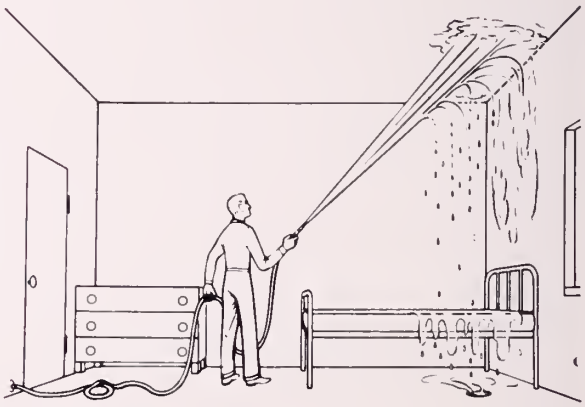

Figure 4. Hosing down hospital rooms (courtesy of the C. V. Mosby Company, Montgomery, T. L.: The Microcosmos and Man, *ibid*).

called for rather than deep analgesia, amnesia or anesthesia. The use of local and regional anesthetics is encouraged.

Indications for operative delivery have been commented on and the shift from difficult vaginal

manipulation to cesarean section approved. Nothing is found wrong with spontaneous delivery in normally progressing cases.

Physiologic relationship of baby, cord and placenta have been discussed and late severance and ligation of the cord recommended.

The responsibilities of the obstetrician and the immediate care of the newborn in the delivery room have been defined and listed.

Rooming-in of mother and baby has been recommended as the procedure offering best

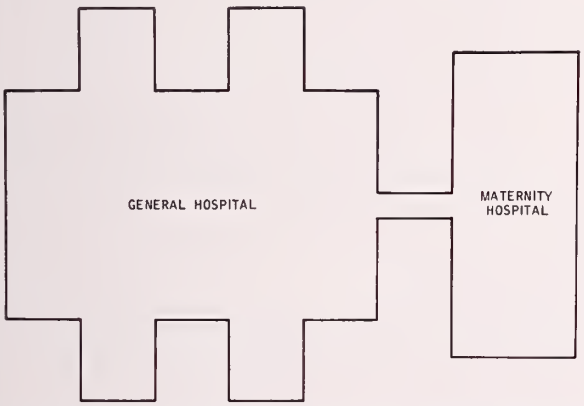

Figure 5. Separation of the maternity wing from the general hospital (courtesy of The C. V. Mosby Company, Montgomery, T. L.: The Microcosmos and Man, *ibid*).

protection against infection and the highest degree of newborn care.

Suggestions for improvement in hospital architecture favorable to fetal interests have been proposed.

The responsibility of the obstetrician in considering problems of hospital infection as they relate to the hospital maternity have been pointed out.

Finally, in the light of these various considerations it is hoped that you will agree and act upon the slogan, "Delivery is for the Baby."

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. . . a man never tells you anything until you contradict him.

George Bernard Shaw.

Incidence of Trichiniasis Among Rats In the Beckley Area of West Virginia

Joseph E. McCoy, M. T. (ASCP), Santo Briguglio, M. T., and Clifford D. Reiber, M. D.

It has been demonstrated that in certain parts of the United States various species of wildlife, especially rats, act as reservoirs of Trichinella spiralis and may continue to play a significant role in perpetuating trichiniasis in swine. The Second National Conference on Trichinosis, in 1954, recommended that species of wildlife be examined to determine the incidence of trichiniasis. Since, to our knowledge, no such survey has been made in this region to establish the incidence of trichiniasis among rats, an important reservoir host, this study was undertaken.

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Materials and Methods

One hundred rats were collected from the Beckley area between April 19 and May 18, 1961. The city dump was chosen as the collection site because of the rodents' ready availability. Most of the animals were easily identified as Rattus norvegicus, the Norway rat, using as criterion the length of the tail being shorter than the combined length of the body and head. No attempt was made to enumerate the numbers of males and females. The animals were killed at the collection site.

Autopsies were performed within twenty hours after death, and the entire diaphragmatic muscle removed, since the encysted larvae of Trichinella spiralis are readily found in this structure. Each diaphragm was placed between two large glass slides and pressed by means of two metal frames held together by four nuts and bolts, one set on each corner. An examination of the entire diaphragm was made for the presence of encysted larvae using a wide-field stereomicroscope with 4X objectives and 10X oculars giving a field of approximately 4.5 mm. in diameter. A semi-mechanical stage and substage illuminating device designed by one of us (J. E. M.) was used to expedite the examination and to insure that no area of the diaphragm was missed.

Results

Twenty-seven of the one hundred rat diaphragms examined contained encysted larvae of Trichinella spiralis. The number of encysted larvae per microscopic field, indicated in Table 1, was used to determine the degree of infection.

Table 1

Encysted larvae per microscopic field	*Number of rats*
No encysted larvae observed	73
1 cyst every 6-8 fields	6
1 cyst every other field	6
1 cyst per field	2
5-15 cysts per field	4
16-25 cysts per field	5
35 cysts per field	1
Too numerous to count	3

Discussion

Man ordinarily is infected with Trichinella spiralis by ingesting improperly cooked trichinous pork. Swine usually are infected by ingesting untreated garbage containing trichinous meat and occasionally by eating infected rats. Infection is spread among rats by the ingestion of garbage containing encysted larvae and by cannibalism. According to several workers[1, 2] swine and other animals also may be infected, under certain conditions, by ingesting food contaminated with feces from rats which had recently eaten trichinous meat.

The finding of a moderately high incidence of infected rats in the Beckley area indicates a potential source of Trichinella spiralis. It also may reflect to some extent the degree of contamination of garbage which was deposited at this particular site. In a recent survey[2] of Norway rats from the city dump of Fort Collins, Colorado, only 17.8 per cent were found to be infected as

Submitted to the Publication Committee, August 28, 1961.

compared with 27 per cent found in this survey. Since garbage upon which the rats studied were feeding was collected from multiple points throughout the Beckley area, no conclusion can be drawn as to the specific source of contamination with Trichinella spiralis nor to the relative incidence of trichiniasis in swine in this locale.

Summary

In a study of one hundred rats from the Beckley area of West Virginia, 27 per cent were infected with Trichinella spiralis. This indicates a potential source of infection for swine and ultimately, man. In view of the relatively large number of infected rats found in the survey, it would seem advisable that similar studies of other species of wildlife in the same region be undertaken.

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'Eternal Vigilance'

You know that not many of the professions enjoy the freedom that the doctors of America do. I wonder if you have ever taken time to stop and think of the many things that you can do without any restrictions whatsoever. Certainly the unions do not have this privilege, for they are restricted by the number of hours that they can work, the membership in the union is more or less compulsory, your privileges are determined by the union, and the amount that you can even make. Of course, in medicine you belong to your various societies, starting at the county level, but then there is not a "mop-up squad" that is going to force you to join. You work as hard or as little as you desire, make as much as you want and charge what you think the service is worth. Perhaps this last statement is the most misused and abused of all the freedoms that we, as doctors, enjoy. It is not generally abused and not misused by the majority, but the minority that do abuse and misuse, paint the picture that all doctors of medicine are sometimes accused of resembling.

There are other things that a minority of the doctors have done, and in some cases are doing, that reflect on the majority, and this is most unfortunate, but as long as the majority go about doing the good that they do, being honest in their work, and to their patients. I believe that we can and will continue to have these freedoms that we enjoy now. However, they will not continue to exist, unless each individual takes it upon himself to see that medicine's image (if you care to call it that) is the reflection of you and all the other doctors like you, who are trying to deliver the best and most conscientious service to the patients that they serve, and at the most reasonable cost that is possible to do this service.

I may be wrong, but it seems to me that it was Patrick Henry that said; "The price of Liberty is eternal vigilance." This applies to the practice of Medicine as well as any other profession, for the deprivation of your freedom in the selection of your patients, the choice of treatment, and the pursuance of continued learning, would be the most disastrous catastrophe that could befall this profession that we, and our predecessors, have loved and worked for so well.—Charles N. Wyatt, M. D., in the Journal of the South Carolina Medical Association.

Pulmonary Infarction Complicating Mumps*

(Case Report with Review of Uncommon Complications)

G. E. Irvin, M. D.

MUMPS, especially in adults, is not always an innocuous disease, being fraught with potentially serious and lethal complications. Having seen a rather unusual complication of mumps orchitis recently and upon finding it described infrequently in the literature, I felt it worthwhile to report the case together with a review of the less common and often unrecognized features that can occur in a disorder which usually pursues a benign course. The hypothesis will be advanced that in a generalized mumps viremia the initial clinical manifestations will vary, depending upon which organ involvement is dominant and, as a corollary of this, the so-called "complications" may be early expressions of the disease.

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Case Report

First Admission.—C. T. a 31-year-old white male, a coal miner by occupation, was admitted to the Grace Hospital on June 5, 1955, with the chief complaint of painful right testicular swelling of four days' duration. There was a history of typical bilateral epidemic parotitis two weeks before, with recovery. He became ill again with chills, fever of 105 F., vomiting, prostration and testicular swelling. He was seen by his local physician and referred to the hospital. His past health had been excellent, with no previous hospitalizations except for the treatment of a right knee injury several years past. Review by systems was unremarkable.

Physical examination revealed a white male of medium build and average height, weighing 150 pounds, who appeared to be in some distress. The skin was warm, dry and free of eruption or other lesions. Temperature 101.8 F., respirations 18. There was no adenopathy. On eye examination the sclerae were white, conjunctivae slightly injected, pupils equal and reactive. Fundi were negative, extraocular movements normal. Ears and nose negative. The mucous membranes were dehydrated, oropharynx otherwise negative. The neck was supple without palpable adenopathy, distended vessels or goiter. Trachea was in the midline.

The lungs were clear to percussion and auscultation. Blood pressure 110/72. Heart rate 80, normal sinus rhythm, no enlargement nor murmurs. Abdominal examination was unremarkable. Examination of the external genitalia revealed the right testicle to be swollen to three times normal size and very tender to palpation. Rectal examination revealed no masses, only minimal epididymal tenderness. The skeletomuscular and neurologic examinations were negative.

Work-Up and Laboratory.—Hematocrit 42 vol. per cent, leukocytes 4,700 with 70 per cent segmented neutrophils and 30 per cent lymphocytes. Urinalysis negative. Both a routine chest film and electrocardiogram were within normal limits.

Course and Treatment.—The patient was placed on Aqueous ACTH 20 units every 6 hours, salicylates and codeine for pain, and routine supportive measures. His temperature fell by lysis concomitant with symptomatic improvement and he was in condition to be discharged home seven days after admission.

Second Admission.—Readmission became necessary on June 16 (3 days after discharge) because of sharp right lower chest wall pain of pleuritic type, recurrent fever and cough.

Physical examination showed fever (101 F.), inspiratory pain over right lower chest wall with limited motion, and scattered crepitant rales to auscultation in this region. The other physical findings were unchanged except for the testicular swelling which had regressed markedly. No calf tenderness nor swelling was noted. Repeat laboratory studies were unremarkable while a

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Submitted to the Publication Committee, July 29, 1961.

chest film showed a dense area of infiltration at the right lung base with suggestion of fluid (Figure 1).

The patient had rather a stormy hospital course, running a constant fever and with the chest pain continued. The sputum became frankly bloody. Antibiotic in the form of Erythromycin 250 mg. every 6 hours was given and the usual supportive measures were instituted. Repeat chest x-ray on June 21 showed an increasing homogeneous density at the right base extending now to the right hilar level (Figure 2). Diagnostic thoracentesis yielded 650 ml. of blood-tinged fluid. Lesser amounts were removed on two other occasions.

Gradual improvement was noted over the ensuing two weeks, with disappearance of fever, lessening of pain and some improvement of the chest condition on physical examination. X-ray before discharge on June 27 showed partial clearing with loculation changes probably related to thoracentesis (Figure 3). Following hospital discharge the patient gradually regained his former strength and weight over a period of several weeks and returned to work. X-ray on October 8 showed further lung clearing with residuals (Figure 4). There has been no recurrence.

Discussion

The possibility of pulmonary embolism and infarction being etiologically related to mumps orchitis was not considered in this case. The pelvic venous plexus, however, was a likely source of embolism; it is not generally appreciated that the periprostatic plexus is not an uncommon site of venous thrombosis. Review of the literature yielded only three papers dealing specifically with pulmonary infarction in mumps. Cottel and Hauser[1] reported a case in 1952. Lehmus,[2] in 1953, described a case which was similar in many respects to the writer's though of less severity. Young,[3] in 1956, added a third case. It is noteworthy that these cases all were very much alike clinically, having orchitis.

Mumps Virus

The mumps virus belongs to an ever growing list of myxoviruses. They agglutinate red blood cells of certain animal species, can lyse cells and cause a delayed type of allergic reaction. Man is the only known reservoir of infection, though a few laboratory animals may be infected experimentally. The virus has been isolated from various organs and from blood, urine and spinal fluid. The general viremia state has been well documented and probably explains the protean disease manifestations. The virus seems to have a particular affinity for the salivary glands and can be isolated in saliva at least one week before clinical disease is evident.

Figure 1. Dense area of infiltration at right lung base, with suggestion of fluid.

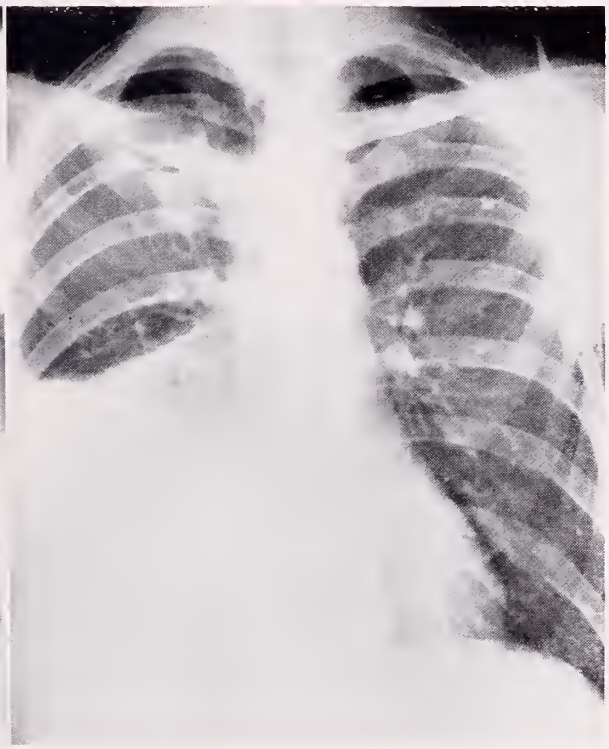

Figure 2. Repeat chest x-ray. Increasing homogeneous density at right base extending to right hilar level.

All strains of the mumps virus are antigenically the same; this is fortunate as one attack of mumps confers life-long immunity. Due to the long incubation period (18-21 days) the patient may have detectable antibodies in his blood by the time clinical symptoms appear; his skin test to mumps antigen may be positive also. Both of these findings may have important diagnostic and therapeutic implications as will be brought out later.

Mumps Complications

In general, mumps causes more serious complications after puberty. For the most part, the following discussion will pertain to this group. In any large series of cases, the complications incidence usually is listed somewhat as follows: Meningo-encephalitis, up to 50 per cent; pancreatitis, 5 to 10 per cent; orchitis, 25 per cent; oophoritis 2 to 5 per cent. Rare involvement of joints, liver, breast, thyroid and heart often are merely mentioned. These complications, albeit unusual, assume importance, however, when we realize that a patient's illness may begin with one of these rare manifestations before the typical parotitis develops and, as we shall learn, may never develop in a sizeable percentage of patients.

Nervous System.—We shall consider the nervous system manifestations first since they constitute a commonly associated feature. The usual clinical expression of meningo-encephalitis is well known. When headache, stiff neck, somnolence and vomiting develop in a patient with parotitis, his spinal fluid shows pleocytosis of 200-600 cells, usually, and slight protein increase. In fact, evidence of meningeal irritation commonly appears even in the absence of headache and stiff neck. In a review of 50 cases of meningo-encephalitis by Field and McLeod,[4] they found the neurologic manifestations preceded the parotid swelling in 6 of 27 cases; in the other 23 (46 per cent) parotid enlargement never did develop. Complete ophthalmoplegia developed in one child for which ventriculography was done to rule out a space occupying lesion. In a 26-year-old woman with stiff neck, back pain and partial extremity weakness the diagnosis made was poliomyelitis. The authors emphasized the importance of the laboratory in diagnostic confirmation in this type of case.

Demonstration of antibody titer rise in paired sera is proof positive. This virus often can be isolated from spinal fluid, but this is hardly necessary. Overman[5] reported two cases presenting with coma in which tumor and unusual encephalitis were the initial diagnoses until laboratory studies were done. Rarely, mumps may be associated with polyneuritis or polyradiculitis, as reported by Porter.[6] His patient, a 17-

Figure 3. Chest x-ray before discharge. Partial clearing, with loculation changes probably related to thoracentesis.

Figure 4. Chest x-ray approximately 3½ months after discharge. Further clearing, with residuals.

year-old female, also showed a "central" type of hypertension that gradually subsided; she had brain stem involvement with tetraplegia and lower cranial nerve paresis. Deafness is a well recognized sequel to mumps. Thus, it is seen that any part of the nervous system may be attacked by the mumps virus, only a few examples being presented here to illustrate the wide diversity of involvement.

Heart.—That the heart may be involved by mumps virus has been well documented since World War I. Marca[7] found upon histopathologic examination acute interstitial myocarditis with fibrinous exudate which he thought was characteristic. Clinical evidence of mumps myocarditis apparently is uncommon. Rarely, a friction rub may be picked up indicating serosal involvement. Sudden heart failure has been described. Changes in serial electrocardiograms may be the only clue. Klinefeld[8] et al, in reviewing the subject, put the incidence of myocardial involvement at about 5 per cent. The electrocardiographic changes are nonspecific including minor degrees of A-V block, inverted or diphasic P wave, elevated ST in chest leads, and T wave changes. Changes are most likely to develop between the first and second week of illness and may take four weeks to disappear. Transient serum transaminase elevation may occur. Retrosternal distress or pain may be the only clinical manifestation of mumps myocarditis. Heart involvement seems to occur in those who are sicker and especially with an associated meningoencephalitis.

Pancreas and Liver.—Mumps pancreatitis is not uncommon. Many patients experience abdominal pain but few have evidence of more than mild inflammation. Zeluff and Fatherree,[9] however, described a patient in whom pancreatitis pursued a prolonged course with a high serum amylase that finally responded dramatically to adrenal steroids. Elkan[10] reported an instance of mesenteric vascular occlusion associated with mumps pancreatitis.

Liver involvement in mumps has been reported infrequently. Warren[11] had a 35-year-old man with typical mumps parotitis followed by jaundice. Following this experience, his next 26 patients with parotitis were subjected to a battery of liver function tests without any striking deviation from the norm. The author again emphasized the "pantropic" nature of mumps virus.

Gonads.—In the post-pubertal male orchitis is almost as common as meningo-encephalitis. In contrast to some of the other "complications," it follows the appearance of parotitis by several days, may be unilateral (40 per cent) or bilateral (60 per cent). Marked pain and prostration are related to inflammatory swelling within the dense tunica albuginea; pressure necrosis of the seminiferous tubules may ensue. This rarely can cause sterility. Attempts to prevent the testis complication have met with only varying success by different measures, including estrogens, gamma globulin and hyperimmune serum. When adrenocorticotropin became available it was used to prevent or to allay the inflammatory reaction. In more recent years the adrenal steroids have been used. Petersdorf and Burnett,[12] in treating 23 patients, reported rapid defervescence of the testicular inflammation and were enthusiastic while Mongan,[13] in a small double blind series, could see no remarkable effect of steroids on the condition. In view, however, of the well documented antiphlogistic effect of steroids in making a very sick patient more comfortable, I think their use is not without merit. Oophoritis in the female usually presents few problems though occasionally a patient is operated on as an appendicitis case.

Thyroid and Breast.—Painful swelling of the breasts and thyroid is not uncommon. In keeping with some of the more recent developments in the ever increasing field of auto-organ sensitization, Brown[14] reported a very interesting case of a 35-year-old woman in which painful thyroid enlargement developed accompanying a typical bout of mumps parotitis; this was followed by progressive hypothyroidism which was symptomatic over a period of 3 to 4 months. The virus was not isolated from the thyroid gland and antibodies were not demonstrable. It was postulated by the author, however, that the mumps virus had invaded the thyroid producing subacute thyroiditis (confirmed by needle biopsy) which destroyed the gland by an antigen antibody mechanism.

Joints.—Articular involvement in mumps seldom has been mentioned in the literature. Scattered reports of single cases have appeared since Wilson's paper, in 1926.[15] Appelbaum[16] et al added 4 cases in which the time interval between parotitis and beginning joint symptoms suggested an antigen-antibody mechanism similar to post-streptococcal rheumatic fever with painful migratory polyarthritis, joint swelling, redness and accompanying tenosynovitis. If only the articular manifestations of mumps infection exist in any given patient confusion with rheumatic fever is likely and a long drawn out course of treatment might be instituted needlessly. Here again the laboratory comes to our aid as the ASO titer will be normal and the mumps serologic test will be

positive. Mumps arthropathy clears up in one to several weeks, subsiding without residuals or fear of recurrence.

Blood.—Spink[17] reported 3 instances of thrombopenia with purpura following mumps in adults, two of which were fairly difficult to manage and came to splenectomy. Adrenal steroids helped control the bleeding tendency without any platelet effect. Again a hypersensitivity mechanism has been hypothecated to explain mumps purpura.

Comment

As we have seen from this brief review of some of the highlights of unusual or unrecognized mumps viremia manifestations, the so-called "complications" probably are merely tissue or organ localized responses to a generalized viremia. The situation seems to me to be somewhat analogous to infectious mononucleosis which at one time was thought to be a blood dyscrasia with few manifestations other than in the lymphatic tissue. In recent years it has been found to be a multisystem disease, often with bizarre and atypical features.

As physicians we are compelled to be familiar with the atypical features or variants of a disease process as common as mumps. Fortunately, very few of the mumps "complications" are severe and recovery is the rule. Since little can be done to prevent them our aim must be directed toward prevention of mumps infection by massive "active" immunization programs. Mumps still causes considerable mass morbidity, especially among children of school age where quarantine measures are difficult and, in fact, useless, since the saliva contains virus at least one week before clinical infection becomes evident. Killed virus has been partially effective in inducing immunity of short duration, whereas the more recent attenuated live virus vaccine developed by Smorodintsen and Kryachko[18] has been found either to prevent mumps altogether or result in a mild infection with lasting immunity. It can be given along with various immunizations and probably in the not too distant future the disease will be all but eradicated. The mumps antigen skin test may have particular usefulness in screening those who are susceptible to infection, and vaccination can be carried out as soon as exposure occurs since antibodies begin to form in as short an interval as 2 to 3 weeks.

Summary and Conclusions

Pulmonary infarction complicating mumps orchitis has been reported. Search of the literature revealed less than six documented cases.

The mumps virus is one of an ever increasing list of myxoviruses producing a generalized viremia state to account for apparent atypical and protean manifestations.

Examples of unusual or unrecognized involvement are given, namely, nervous system, heart, pancreas, liver, gonads, thyroid, joints and blood dyscrasia.

It is to be emphasized that the "complications" may precede the usual parotitis which, in fact, may never develop in a sizeable percentage of cases. This may create diagnostic error unless laboratory facilities are available and utilized. This tends to confirm the organ or tissue localization secondary to viremia concept wherein the so-called "complications" may be, in effect, the primary overt manifestation of mumps.

Finally, with the development of newer live vaccine we can look forward to the control and eventual eradication of mumps as a potentially serious viral infection.

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95TH ANNUAL MEETING

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The President's Page

Laws Are Made By Those You Elect

THE problems of medical care and medical practice will continue to bring us face to face with some of the most complex problems of our times. Without doubt we can expect a continuing effort on the part of our Federal Administration to foist upon the American people some form of socialized medicine during this and subsequent sessions of our Congress.

Reports to the contrary should be viewed with suspicion. The proponents of socialism are dedicated, untiring and intelligent. Opposing governmental interventions in medical practice might be likened to beating out brush fires endlessly. The exercise is nonetheless useful—in the sense rear guard actions are useful. One's ability to oppose fallacies—a negative tactic—appears to be a necessary preface to accenting the positive. Unless an individual can demonstrate competence in exploding socialist error, he is not likely to gain wide audiences for his solutions brought about by interrelations between free men.

The physicians of the United States will continue to oppose compulsory medical programs as being contrary to the Declaration of Independence where it is held that man is endowed with inalienable rights to life and liberty. Thus endowed with freedom of choice each individual can better rely on the self-adapting processes of man in working out problems with which he is confronted rather than submitting to the retarding and stifling influence of governmental control.

Government has no right to the use of untruthful propaganda or coercion to force upon its citizens a way of life which in any way interferes with the peaceful, free interrelationships that have made this a great nation.

After we have surveyed and determined the needs of our people and aims of our profession, by what means shall we meet those needs and accomplish these aims? As we all know, legislative decisions are made in the Congress by our elected representatives. It is important that we lend every effort toward filling our Congress with legislators sympathetic to our campaign of maintenance of freedom of choice as against compulsion in any form.

The mere casting of our individual ballots cannot be considered active support to those legislators who carry the same convictions as those for which we are fighting. We must assist candidates of intelligence and integrity in their campaigns and offer financial support toward the expenses thereof. The pursuit of calm, luxury and ease in these times will solve none of the problems with which we are confronted today.

Last month at the request of Secretary Abraham Ribicoff a task force was set up within the Department of Health, Education and Welfare to push for adoption of a compulsory program of medical care for the aged under the Social Security system. This force, under Assistant Secretary Wilbur Cohen, may be expected to offer "seductive compromises" which ostensibly preserve private enterprise. Regardless of how inocuous any such legislation may appear on the surface, if it is tied into the Social Security approach it continues to remain dangerous to the free practice of medicine in this country.

D. E. Greeneltch

D. E. Greeneltch, M. D., President

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DR. CHARLES E. GOSHEN of Bethesda, Maryland, has accepted appointment as Associate Professor of Psychiatry at the West Virginia University School of Medicine. The appointment was announced last month by Acting University President Clyde L. Colson.

Doctor Goshen, who has been serving as Director of Community Psychiatry with the Maryland State Department of Mental Hygiene, is the author of two books, "Psychiatric Architecture" and "The Day Hospital."

He received his M. D. degree from the Columbia University College of Physicians and Surgeons in 1942. Following World War II army service, he served a two-year residency in psychiatry at the VA Hospital in Bronx, New York. From 1949 to 1952, he attended New York Medical College where he earned a certificate in psychoanalysis.

Doctor Goshen served as Research Director of the American Psychiatric Association, 1957-59, associate with the National Research Council in Washington, 1959-60, and research physician with Operations Research, Inc., Silver Springs, Maryland, 1960-61. He has previous teaching experience at Columbia University and George Washington University.

He is a Fellow of the American Psychiatric Association and the American Association for the Advancement of Science. He is a member of the District of Columbia Medical Society and the American Medical Association.

New Member of Radiology Staff

Dr. Joseph R. McProuty, a native of Grafton, joined the faculty of the School of Medicine on December 1 as Associate Professor of Radiology. Since 1958, he has been in private practice in El Centro, California.

Doctor McProuty was graduated from West Virginia University and received his M. D. degree from the Northwestern University Medical School in 1951. He served a three-year residency in radiology at the VA Center in Los Angeles.

He is certified by the American Board of Radiology and is a member of several professional organizations including the American College of Radiology, Radiological Society of North America, and the Society of Nuclear Medicine.

Additional Staff Appointments

Seven Harrison County physicians recently accepted appointment as members of the clinical faculty at the School of Medicine.

• **Compiled from material furnished by Cletis Pride, Public Information Officer, West Virginia University Medical Center, Morgantown, W. Va.**

Named clinical assistant professors were Dr. Sobisca S. Hall in otolaryngology, Dr. Robert T. Humphries in orthopedics, and Dr. E. Ross Allen in medicine.

Drs. Lawrence B. Thrush and James E. Wilson, Jr., were appointed clinical instructors in surgery, and Dr. Robert S. Wilson in orthopedic surgery. Dr. William N. Walker, Jr., was named clinical instructor in anesthesiology.

Dr. Clark K. Sleeth, Dean of the School of Medicine, said the physicians will carry out their duties primarily at the VA Hospital in Clarksburg which has been designated a Dean's Committee Hospital to help train students in the School of Medicine.

Research Grants

The National Institutes of Health has awarded to members of the School of Medicine faculty $28,159 to continue research in 1962 on the effects of major surgery on body chemistry.

The project, entitled "The Regulation of Electrolyte Balance in Surgery," is under the direction of Dr. Bernard Zimmermann, Professor and Chairman of the Department of Surgery, and Dr. Walter H. Moran, Jr., an instructor in the department.

The investigations are being carried out in conjunction with the University's new metabolic diseases clinic, established by a recent NIH grant of $693,803.

A $15,000 grant from the American Cancer Society has been received by the School of Medicine to support research on malignancies. The grant is administered by the University Cancer Committee, which allocates the funds to faculty members engaged in promising investigations in the field.

Dr. Bernard Zimmermann, chairman of the committee, said five research projects already have been approved for inclusion in the program. He said funds will be available for additional grants throughout the year. In addition to the School of Medicine's basic science and clinical departments, faculty members pursuing cancer research throughout the University are eligible to participate.

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1. Ford, R. V.: "Human Pharmacology of a New Non-Mercurial Diuretic: Benzthiazide," Cur. Ther. Research, 2:51, 1960.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE Kennedy Administration and other main supporters of medical care of the aged under social security are preparing to make an all-out effort to push the legislation through Congress in the 1962 session. Their campaign poses a serious challenge to the medical profession and its allies in the fight against such compulsory government health schemes.

It is too early to evaluate the effect on the legislation of changes in House Democratic leadership and House Ways and Means Committee membership. The White House has been exerting pressure in an effort to have a congressman supporting its views named as a replacement for Rep. Frank Ikard (D., Tex.), who resigned. Ikard opposed proposals to put health care under social security.

Top Priority

Administration officials from President Kennedy down publicly gave the Administration medical care legislation, the King-Anderson bill, top priority for the 1962 session. During the interim after the adjournment of the 1961 session, the Administration held a political roadshow in key cities in an effort to build up public support for the King-Anderson bill and other Administration proposals that did not fare so well in Congress. At a number of the so-called White House Regional Conferences, physicians forcefully expressed the medical profession's opposition to putting health care under social security.

The AFL-CIO geared for a renewed fight for the Administration's legislation. A new national organization of the elderly has been formed with the main purpose of lobbying for the King-Anderson bill. It is the National Council of Senior Citizens for Health Care Through Social Security. Former Rep. Aime J. Forand (D., R. I.), who sponsored such legislation when he was in Congress was the leading figure in organizing the group and is national chairman.

AMPAC

On the other side of the fight, there also is a new organization—The American Medical Political Action Committee. It is a non-profit, voluntary, non-partisan, unincorporated committee setup last May with the approval of the AMA Board of Trustees. AMPAC, which functions independently of medical organizations and societies whether at the national, state or local level, was organized to meet "an unmet need—the need of providing the medical profession with an opportunity to assume a more active and effective role in public affairs." The AMA Board of Trustees report to the House of Delegates at Denver urged that all physicians, their wives and interested friends join AMPAC and similar political action committees in their states and communities.

Dr. Leonard W. Larson, AMA president, warned the House of Delegates that physicians "are engaged in a historic struggle to preserve our country's unique system of medical care and our stature as a profession." He said both are "seriously threatened" by such legislative proposals as the King-Anderson bill.

Doctor Larson said that the AMA could expect "even more bitter attacks" than those so far from Administration and AFL-CIO spokesmen. He appealed to physicians to support medicine's friends in Congress with money and personal campaign assistance.

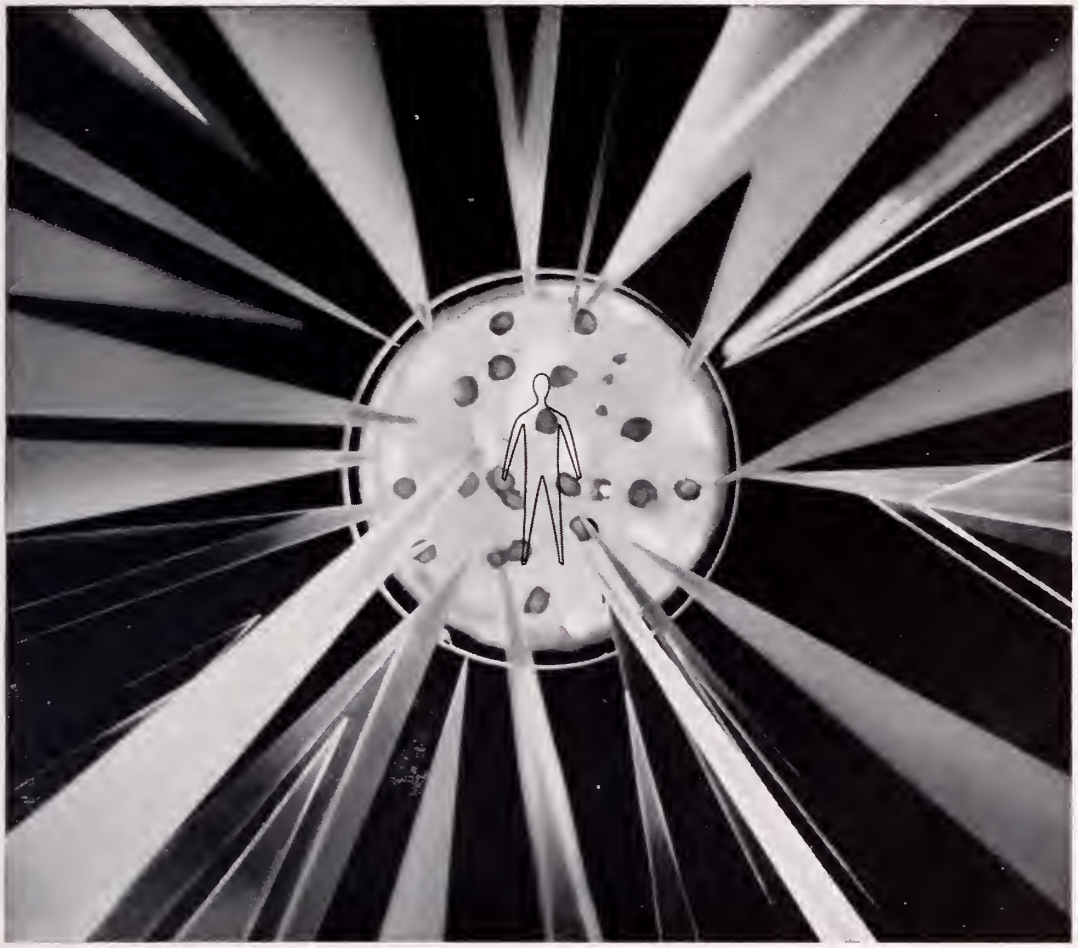
'A Determined Drive'

A leading congressional opponent of health care under social security also warned of the seriousness of the fight ahead. Sen. Wallace F. Bennett (R., Utah), a member of the Senate Finance Committee which handles such legislation, told students at Harvard Medical School that there undoubtedly would be "a determined drive to rush H.R. 4222 (the King-Anderson bill) through the Congress" in 1962.

"The propagandists who are behind the determined drive for a system of socialized medicine have latched on to an emotional appeal in trying to push this legislation through the Congress," Bennett said. "They have tried to create a public image that the AMA and any individual who opposes this plan is motivated by selfish interests.

"As one who is vigorously opposed to compulsory Federal medical care, I resent the tactics used by those who advocate this system of socialized medicine. There is an answer to this problem of meeting the medical needs of our aged, and I frankly believe that it is being honestly met by our present voluntary health insurance programs and by the cooperative federal-state aid to our needy aged who are incapable of paying their own medical expenses.

"I am opposed to H.R. 4222 or other bills which would open the flood gates to a system of compulsory medical care, directed first to our aged, but which, once instituted, would surely by political pressure be expanded to all of our population. The battle over this legislation in this next Congress is bound to be hectic and monumental. It is a battle we can't afford to lose."



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Obituaries

WILLIAM EDWARD ECHOLS, M. D.

Dr. William Edward Echols, 87, who practiced medicine for nearly 60 years in Richwood, died at his home in that community on November 17.

Doctor Echols was born at Gravel Springs Farm near Lewisburg on October 29, 1874, son of the late John Jordon and Sara Elizabeth Echols. He attended Gilmore Military School and received his M. D. degree in 1898 from the Baltimore Medical College (now University of Maryland School of Medicine). He took postgraduate work in Baltimore, New York City and New Orleans.

He was licensed to practice in West Virginia in 1898 and located in Monongah that same year. He relocated his practice at Richwood in 1902, where he practiced continuously until his retirement in 1959.

Doctor Echols was a founder of Sacred Heart Hospital, built in Richwood in 1912, and for several years served as chief of staff of the new Sacred Heart Hospital which opened in 1953. He served several terms on the Nicholas County Board of Education.

He was an honorary life member of the Central West Virginia Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a son, Dr. John E. Echols of Richwood, a daughter, Mrs. Alice Echols Barnette of Wilmington, Delaware; a stepson, Okey Lee Mearns of Charleston; two brothers, John and Charles of Lewisburg; a sister, Mrs. Baxter Neel of Gap Mills; and five grandchildren.

Freedom or Security

It is a serious blunder to consider that the Welfare State of the social planners differs from socialism or communism except in degree. The Welfare State would stifle individual liberty by means of a host of Federal regulations. We would become puppets of the Federal bureaucrats. These planners use taxes not simply to defray the cost of government, but to spread the wealth. They frankly admit that such Forand type legislation as the current King bill to give health care to the recipients of Social Security is just the beginning. Their goal is complete medical care for all covered by Social Security. As Senator Byrd and others have said, the Federal Government cannot spend tax dollars in this manner without setting up regulations for its use. This means ultimate domination of both the physician and the patient by the government.

It is not only in the field of medicine but in education, agriculture, public housing, and other areas where welfare planners seek to establish Federal control. Let us recognize that all such efforts endanger our freedom. Let us, on this anniversary of our national independence, dedicate "our lives, our fortunes, and our sacred honor" to the preservation of the basic philosophy that made America great.—John G. Slevin, M. D., in Detroit Medical News.

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County Societies

BARBOUR-RANDOLPH-TUCKER

Dr. Barbara Jones of Morgantown was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker County Medical Society which was held at Blackwater Falls Lodge in Davis on November 16.

Doctor Jones, who is assistant professor of pediatrics at the WVU School of Medicine, presented a paper on "Hemolytic Diseases of Childhood." She presented the pre-clinical background of the hemolytic diseases, along with current methods of investigation and testing, and then discussed the clinical aspect of the hemolytic diseases, their classification, diagnoses and principles of management. A question and answer period followed.

Dr. John L. Rittmeyer, the president, presided at the business meeting. He named Dr. Donald R. Roberts as chairman of the Medical Emergency and Civil Defense Committee.

Doctor Rittmeyer urged that every member of the Society be contacted and encouraged to give individual contributions to the Charles Lively Memorial Scholarship Fund. Dr. H. L. Jellinek, the treasurer, was named chairman of the committee.

Eighteen members and one guest attended the meeting.—Charles L. Leonard, M. D., Secretary.

* * * *

CABELL

Dr. Benjamin Felson was the guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on November 9.

Doctor Felson, who is Professor of Radiology at the University of Cincinnati School of Medicine, presented an interesting paper on "Some Fundamentals in Chest Roentgenology." A question and answer period followed the presentation of the paper.

Dr. C. Stafford Clay, the president, presided at the business meeting. He announced that Drs. Charles A. Hoffman, Jr., and Thomas G. McKee had been elected to membership in the Society.

In response to a letter from Dr. D. E. Greeneltch of Wheeling, president of the West Virginia State Medical Association, Doctor Clay urged all members of the Society to actively support the Charles Lively Memorial Scholarship Fund.—W. L. Neal, M. D., Secretary.

* * * *

MASON

Dr. Philip Lisan of Philadelphia was the guest speaker at the regular bi-monthly dinner meeting of the Mason County Medical Society which was held at the Gene Ball Restaurant in Pt. Pleasant on November 13.

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Doctor Lisan, who is a member of the faculty of the Hahnemann Medical College, presented an interesting paper on "Recent Advances in the Management of Atherosclerosis." He appeared through the courtesy of the Merck, Sharp and Dohme Postgraduate Program.

New officers for the coming year were elected during the business meeting. Dr. Don F. Hatten was elected president and Dr. J. Berrye Worsham, Jr., was named secretary-treasurer.

Dr. Lewis D. Telle, the retiring president, presided at the meeting.—Dan Glassman, M. D., Secretary.

* * * *

MERCER

Drs. Pat A. Tuckwiller and James H. Getzen of Charleston were the guest speakers at the regular monthly meeting of the Mercer County Medical Society which was held at the West Virginian Hotel in Bluefield on November 13.

Doctor Tuckwiller presented an interesting talk on the treatment of duodenal ulcer, in which he discussed the etiology of peptic ulcer and its medical treatment with anticholenergics, antiacids and surgery.

Doctor Getzen discussed differential diagnoses of jaundice. He explained the various liver function tests and the diagnosis of pre-hepatic jaundice, infectious jaundice and obstructive jaundice.

During the business meeting, Drs. Upshur Higginbotham, Gordon L. Todd, Jr., Hampton St. Clair and Sam Milchin were appointed members of the Nominating Committee to select officers for 1962.

It was announced that a 200-bed emergency hospital is available for use in connection with civil defense training exercises. The members of the Society promised their support in this important project.

Dr. Henry F. Warden, Jr., the president, presided at the meeting which was attended by 33 members.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. Robert J. Marshall was the speaker at the regular monthly meeting of Monongalia County Medical Society which was held at the Hotel Morgan in Morgantown on November 7. He was introduced by Dr. R. F. Krause.

Doctor Marshall, who is associate professor of medicine at the West Virginia University School of Medicine, presented an interesting paper on "Regulation of Cardiac Output." A question and answer period followed.

The secretary, Dr. C. C. Romine, presided at the business meeting. Dr. Ralph W. Ryan announced that containers for enucleated eyes for the Eye Bank have been distributed to hospitals in the area.

Dr. J. C. Pickett urged members to contribute individually to the Charles Lively Memorial Scholarship Fund.—John H. Trotter, M. D., Acting Secretary.

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Recording Secretary: Mrs. J. A. B. Holt, Charleston
Corresponding Secretary: Mrs. Fred Moomau, Petersburg
Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

HANCOCK

The regular monthly meeting of the Woman's Auxiliary to the Hancock County Medical Society was held at the Williams Country Club in Weirton on November 21.

Mrs. E. L. Clubb, Jr., the president, presided at the meeting which was attended by eleven members and one guest. Mrs. Thomas G. Harper and Mrs. Theodore R. Whittaker presented committee reports during the business meeting.

A letter of thanks was read from Mr. Charles Okey, administrator of Weirton General Hospital, in which he thanked the Auxiliary for its annual contribution to the Hospital Medical Library.—Mrs. Thomas G. Harper, Correspondent.

* * * *

McDOWELL

Mr. E. L. St. Clair was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the McDowell County Medical Society which was held at the home of Dr. and Mrs. A. A. Carr in War on November 8.

Mr. St. Clair, who is president of the McDowell County Court, presented an interesting talk on "Why Fallout Shelters." He pointed out that McDowell County was one of the first counties in the United States to formulate a civil defense program. He said that the plan was published in booklet form in 1957 and has been used as the basis for other county defense programs in this and other states.

Twenty-four boxes of AMEF playing cards were sold to members during the meeting.—Mrs. F. L. Johnston, Publicity Chairman.

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MONONGALIA

Dr. John J. Lawless of Morgantown was the guest speaker at the November meeting of the Woman's Auxiliary to the Monongalia County Medical Society which was held at the Morgantown Golf and Country Club.

Doctor Lawless, who is Director of the WVU Health Service, presented a talk on "Personal and Community Responsibilities in Civil Defense."

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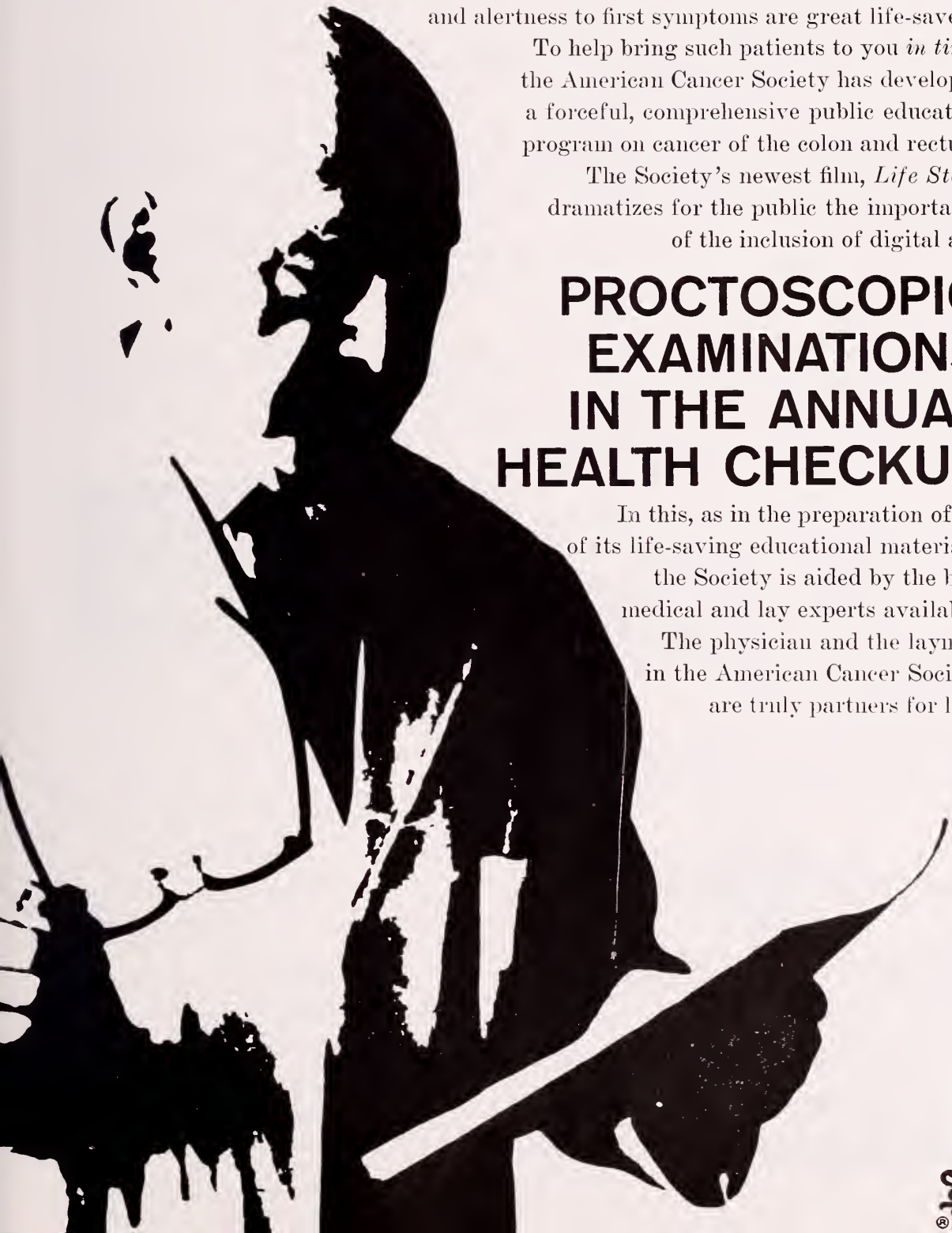

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HUNTINGTON, WEST VIRGINIA

A Christmas luncheon was held at the WVU Medical Center in December.

Members of the Auxiliary made individual contributions during the meeting to finance the annual Christmas gift for children at the St. Mary's Training School for retarded children.—Mrs. J. J. Lawless, Publicity Chairman.

* * * *

OHIO

The regular monthly meeting of the Woman's Auxiliary to the Ohio County Medical Society was held at Wilson Lodge in Wheeling on November 28.

Mrs. Howard G. Weiler and Mrs. W. E. Ackermann served as auctioneers at a white elephant sale held in connection with the meeting. Proceeds from the sale were contributed to the Health Careers Pin Fund.

Hostesses for the luncheon meeting were Mrs. Paul H. Cope, chairman, and Mesdames James A. Jacob, Frank M. Hudson, S. S. Bobes and C. J. Holley.

Mrs. George M. Kellas, the president, presided at a business meeting which preceded the sale.—Mrs. Daniel B. Gordon, Correspondent.

* * * *

WOOD

The regular monthly meeting of the Woman's Auxiliary to the Parkersburg Academy of Medicine was held at the home of Dr. and Mrs. Charles W. Thacker in Parkersburg on November 14. Mrs. George Gevas, the president, presided at the business meeting.

Radiology:
KARL J. MYERS, M. D.

Clinical Pathology:
E. E. MYERS, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Anatomic Pathalogy:
S. D. WU, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

Resident Staff:
ORAL E. BARKAY, M. D.
LEOPOLDO I. PENA, M. D.
TADAO NAGASHIMA, M. D.

THE MYERS CLINIC
Philippi, West Virginia

Mrs. Lyle D. Vincent announced that plans are being made for the "Dogwood Ball" which will be held on May 5. Proceeds from the dance will be used for the nurses recreational funds at local hospitals and a part of the proceeds also will be contributed to the AMEF.

Hostesses for the meeting were Mrs. Thacker, chairman, and Mesdames Jack J. Stark, Robert K. Fankhauser, Watson F. Rogers and William E. Gilmore.—Mrs. Robert A. McDougal, Correspondent.

* * * *

WYOMING

A joint luncheon meeting of the Woman's Auxiliaries to the Boone and Wyoming County Medical Societies was held at the Glass House in Beckley on November 15.

Guest speakers at the meeting were Mrs. Vernon L. Dyer of Petersburg, president of the State Auxiliary, and Mrs. John W. Hash of Charleston, first vice president.

Mrs. R. C. Hatfield, president of the Wyoming Auxiliary, presided at the meeting which was attended by more than fifteen members and guests from Wyoming and Boone Counties.—Mrs. Ward Wylie, Correspondent.

I like trees because they seem more resigned to the way they have to live than other things do.—Willa Cather.

Book Reviews

TECHNIQUES OF THORACOTOMY.—By B. T. Le Roux, M. D., Senior Registrar, Regional Thoracic Unit, Edinburgh. Foreword by Sir Clement Price Thomas, M. D. Pp. 94, with illustrations by the Medical Photography Unit, University of Edinburgh. The Williams & Wilkins Co., 428 East Preston Street, Baltimore 2, Maryland. 1961. Price $11.00.

Two third-year surgical residents who have had considerable experience in thoracic surgery were asked to review the book. Both liked the book and I am enclosing the comments of one. "From the standpoint of the surgical resident, it is an excellent review of the various approaches to the chest cavity with especial attention given by the author to all the details involved. At the same time, we find that removal of ribs is usual in most of the incisions described, whereas in this country this practice is not as common. Since on many occasions thoracic books are not very descriptive of the techniques of thoracotomy, this review seems to fill its purpose quite well."

The instruments described in the book are not the ones used in most thoracic clinics in the United States. The average resident trainee in the United States would not be familiar with these instruments. The book was well written and covers many fine points. It is an excellent book for beginners but for a physician with advanced training in thoracic surgery or for a

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trained thoracic surgeon it is very elementary except for the review in anatomy.

The principles and descriptions are good but every large clinic has its own way of teaching residents to enter the chest. The resident reading this book must have an open mind and be prepared to adapt, except for anatomical descriptions, to his own clinic. I also do not believe it is good practice to routinely postoperatively bronchoscope patients, as good tracheal bronchial cleaning by the anesthetist prior to removing the endotracheal tube is quite satisfactory along with good postoperative care and nasotracheal suction as indicated.—Morris H. O'Dell, M. D.

* * * *

EXECUTIVES' HEALTH SECRETS—By William P. Shepard, M. D., Former Medical Director of the Metropolitan Life Insurance Company. Pp. 268. The Bobbs-Merrill Company, Inc., 3 West 57th Street, New York 19, N. Y. 1961. Price $4.95.

In the light of recent developments in the concern shown by corporate industrial organizations for the health of their executive employees, this book will be of interest to all physicians, but perhaps of greater value to those medical individuals and groups which devote a major portion of their activities to the stated and follow-up medical examination of and consultation with these valuable employees.

The author, Dr. William Shepard, has the background of many years experience in public health work, and as medical director of a large insurance company, which is combined with an interesting style of concise but complete narration.

There is a lot of philosophy in his content, and many physicians are sometimes deficient or lackadaisical in their every day approach to potentially serious problems.

I would recommend it for both lay and professional reading. It has a lot of bang for each buck.—James S. Klumpp, M. D.

* * * *

SOMATIC STABILITY OF THE NEWLY BORN—Edited by G. E. Wolstenholme and Mave O'Connor. Pp. 393. Little, Brown and Company, Boston. 1961. Price $10.00.

This book presents a symposium of the Ciba Foundation, in cooperation with the Neonatal Society, considering in a manner as comprehensible as possible the somatic stability in the newborn.

It stresses kidney function, metabolic effects of fasting and foods, the stability of the cardiovascular system, the routine evaluation function in the newborn and much other material relative to the neonatal soma.

* * * *

VIRUS MENINGO—ENCEPHALITIS—Little, Brown and Company, Boston, Massachu etts. Pp. 128. 1961.

This 118-page volume, the seventh Ciba Foundation publication, is a transcription of proceedings of an international conference on viral infections of the central nervous system. The twenty-three participants represent a distinguished mixture of clinicians, neurologists, neuropathologists and virologists.

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Interest in this important subject has been greatly intensified in the past decade, not only because of the more refined methods of virus identification and culture now available, but because of the finding that many cases of "non-paralytic polio" (and some paralytic cases as well) were actually caused by Coxsackie viruses. Subsequently, members of the ECHO virus group were also found to be capable of inducing lymphocytic meningitis or encephalomyelitis. Thus, the list of enteric meningotropicneurotropic viruses has steadily increased in recent years.

This booklet emphasizes the "newer" neurotropic viruses and the clinical syndromes they may produce. Discussion of polio is confined to the unusual encephalitic manifestations of this virus; and lymphocytic choriomeningitis, mumps and herpes simplex receive only brief attention. Since it is an internal symposium, tick-borne encephalitis and arbo-virus encephalitis are discussed in some detail, although these diseases have been confined largely to Europe and Asia.

There is much of interest to the clinician here, especially the discussions of clinical syndromes illustrated with case presentations, and listing of characteristic cerebrospinal fluid abnormalities. Of course, a specific etiologic diagnosis cannot be made from the clinical or pathologic picture, but is dependent upon virologic and serologic studies. Laboratory facilities for the latter are increasingly available to the practicing clinician.

Encephalitides may be divided into two main groups: Primary and secondary. The secondary type *follows* infection or immunization (post-influenzal, post-measles, post-vaccinial); and it is thought to represent a neuro-allergic reaction. The discussions of the latter expose our abyssmal ignorance of this important subject, but are nonetheless stimulating.

This book provides something of value for practically every physician, but it would be of particular interest to internists, pediatricians and neurologists.—John F. Otto, Jr., M. D.

If a philosophy is to bring happiness it should be inspired by kindly feelings. Marx pretended that he wanted the happiness of the proletariat; what he really wanted was the unhappiness of the bourgeois.—Bertrand Russell.

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FEBRUARY
1962

Vol. 58 No. 2

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone Dickens 4-4625.

Member 1962

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Official Organ of the West Virginia State Medical Association

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

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EDITORIALS

AGING COMES OF AGE

At the Edgewater Beach Hotel in Chicago, December 15-16, 1961, there was held a most remarkable symposium on aging under the auspices of the Joint Council to Improve the Health Care of the Aged. The meeting was sponsored by the American Dental, Hospital, Medical and Nursing Home Associations. It had as participants in the program doctors of medicine, philosophy and dental surgery, economists, sociologists, nurses, statisticians, a biologist, a representative of Blue Cross and Blue Shield, a noted actor of stage, screen and television, and a minister of the gospel.

Before attending the meeting this writer had no conception of many of the complicated processes which were described as a part of growing old either gracefully or any other way. I am sure some of our readers do not know of the tremendous number of factors which have already been discovered as having a bearing on our cells, our tissues, our emotions, reactions to our environment and each other, and the problems which we are presenting to this old earth upon which we dwell.

Aging was said to be the sum of all deleterious change which ultimately ends in death. Hence we were told that the cells with which we were born and the environment, internal as well as external, in which those cells grew, developed, matured and met the stress placed upon them, were it enzymatic biological, physiological or ultrasonic, played a stellar role in aging from concept to expiration.

These factors in aging have been going on for eons but the external environment has been changing, and we must plan to adjust and react to that change in a manner which will perpetuate and improve homo sapiens in the centuries to come rather than relaxing, deteriorating and allowing the insects to take over. Consequently doctors are conscientiously struggling to maintain the physical and mental health of men, women and children in order to permit them to grow old and enjoy the later years even well past the Biblical three score and ten. Nurses and health technicians are playing an integral part in that struggle. Dentists are providing the health in the mouth and the support to the face and mastication which aids the aged to maintain health, morale and the beauty of their features.

The economists, sociologists, nursing home administrators and ancillary personnel, too numerous to record, are accomplishing wonders in our Novo urban society to make living longer a more comfortable and pleasurable process.

Several members of the symposium spoke of the average life span as soon reaching 100 years.

One wonders whether we will soon be like the old couple with the one room cabin and the family reunion. Where are we going to put the youngsters?

PAPERBACKS IN MEDICINE

The ubiquitous paperback in other forms of literature has invaded the medical field and owing to the inflated cost of publishing medical books, this may be well worthwhile, especially in areas of medical knowledge requiring revision every year or two. One of the foremost medical publishers, the W. B. Saunders Company of Philadelphia, has brought out two such volumes within the last few months.

The first, The Mayo Clinic Dietetic Manual (third edition), with a spiral binding, is the last word in practical dietetics as currently practiced by the physicians and paramedical personnel at The Mayo Clinic and associated hospitals. The work is prepared not for the laity but as a guide to professional persons, doctors, nurses, dietitians, and the like. It covers the whole gamut of life from the newborn to the aged, and all varieties of diet from general to clear liquid. Height—weight—age tables from birth to age 18; from 19 to 25; and 25 plus add definite value and the discussions of the compositions of the various foods are clear and complete. Except for the dietary program on gout, we did not note any discussion of diet in arthritis which confirms our own long held opinion that diet in other arthritic conditions is of no avail.

The second paperback from the same firm is: "Medical Almanac, 1961-62." This volume of better than 500 pages presents more statistical data on medicine and paramedicine than we have ever seen in one volume. It is a compilation of general information, statistics and other data relating to medical care, medical education, medical organizations and literature, the morbidity and mortality rates, and the economic aspects of medicine and illness generally. The AMA organization is very well outlined.

This volume was compiled by Peter S. Nagan, A. B., M. A., M. S., about whom we can find out very little. But he has done an excellent job and we cannot imagine how he has kept out of Who's Who in America. This work certainly entitles him to be listed there and we hereby nominate him for this honor, for we believe the Marquis Company must have unintentionally overlooked him.

These volumes are both outstanding and we look forward to other worth-while "Paperbacks in Medicine."

NO RESPONSIBILITY—NO FREEDOM

There is no indication of any abatement in the public thirst for more social security benefits, for more people, for more things. In fact, the growing tendency is to get progressively farther away from the concept of social security as an "old folks' pension," and to view it as a universal source of economic support for all people in all circumstances.

It is difficult to say how far along this way of transition we can travel before the balance clearly and unmistakably shifts from a society based, fundamentally, upon the concept of the individual's obligation to support himself, to a society based, fundamentally, upon the concept of the government's obligation to support each individual. Clearly, however, we have already reached that grey area, where the one becomes inextricably merged and entangled with the other, and many persons who profess continued faith in the former concept, eagerly pursue the latter.

Perhaps this is, as the "liberals" declare, the next great forward step of mankind in the fulfillment of human "dignity"; but it should be recognized that human needs are not necessarily filled by transferring the responsibility for filling them from the individual to the government; that individual and personal responsibilities can not be surrendered without a proportionate surrender of freedom; and that our Nation had its origin in the belief that centralization of authority means tyranny.—*West Virginia Farm News.*

Emergency Resuscitation

In recent years, a very old method of pulmonary ventilation and a new technique of cardiac resuscitation have been demonstrated to be the most effective combination for restoring to life individuals with sudden unexpected cardio-pulmonary failure.

Mouth to mouth breathing, a technique of artificial respiration mentioned in the Bible, has in the past few years been accepted by all authorities as the most effective method of emergency ventilation of the lungs. Closed cardiac massage, as described by the Johns Hopkins group, has been demonstrated to be a reliable method of circulating blood. It is as effective as open cardiac massage and not fraught with the problems of opening a chest, the need for absolutely certain diagnosis of cardiac arrest and the numerous medico-legal implications of this latter procedure.

All physicians should be thoroughly familiar with this life-saving technique.—Westchester Medical Bulletin.

Experience is a poor guide to man, and is seldom followed. What really teaches a man is not experience, but observation.—H. L. Mencken.

GENERAL NEWS

Dr. George M. Fister To Speak At 95th Annual Meeting

The Program Committee has announced that Dr. George M. Fister of Ogden, Utah, who will be installed as president of the American Medical Association at the annual meeting in Chicago in June, will be among the guest speakers at the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25.

Dr. Halvard Wanger of Shepherdstown, the chairman, said that Doctor Fister has accepted an invitation to be the guest speaker before the final session of the House of Delegates on Saturday afternoon, August 25.

George M. Fister, M. D., President Elect
American Medical Association

Native of Utah

Doctor Fister was born in Logan, Utah, and was graduated from Utah State University. He received his M. D. degree in 1918 from Rush Medical College in Chicago. After interning at Henry Ford Hospital in Detroit, he engaged in general practice for four years in Brigham City, Utah.

He then returned East for special studies in the field of urology and did postgraduate work in London and Vienna. He then returned to Ogden where he has been engaged in the practice of his specialty continuously since 1928.

A past president of the Western Section of the American Urological Association, Doctor Fister serves as clinical lecturer in surgery at the University of Utah College of Medicine. He has written a number of scientific papers on various types of genitourinary tract diseases.

Doctor Fister is now serving on the Board of Regents of the University of Utah, and is a member of the Board's Medical College Advisory Committee.

Active in Organized Medicine

He is a past president of the Utah State Medical Association and an organizer and past president of the Ogden Surgical Society. He served for several years as Utah's delegate to the AMA House of Delegates and was chairman of the AMA Council on Legislative Activities. He has been a member of the AMA Board of Trustees since 1957.

Doctor Fister was named president elect during the 1961 annual meeting in New York City and he will be installed as the 116th president of the Association on June 26, 1962, during the annual meeting in Chicago.

Program Committee Busy

The Program Committee has been busy since the final day of the 1961 meeting making plans for the 95th Annual Meeting in August. A meeting of the committee was held in Martinsburg on October 28.

In addition to Doctor Wanger, the other members of the Committee are Drs. George P. Heffner of Charleston and Charles D. Hershey of Wheeling.

The Committee has announced that general scientific sessions will be held on Thursday, Friday and Saturday mornings, August 23-25. Meetings of the Association's sections and affiliated societies and associations will be held during the afternoon hours.

Some of the nation's most prominent physicians and surgeons have accepted invitations to be among the guest speakers. Their names will be announced in *The Journal* during the coming months.

Two Sessions of House of Delegates

The Association's House of Delegates will meet twice during the meeting. The first session will be held on Wednesday evening, August 22, and the second session on Saturday afternoon, August 25.

Dr. D. E. Greeneltch of Wheeling, the president, will deliver his presidential address before the first session and Doctor Fister will speak before the second session.

New West Virginia Wing

General scientific sessions will be held in the new West Virginia Wing which is scheduled for completion by early summer. In addition to the morning sessions, afternoon meetings of several of the larger sections and affiliated societies will be held in the two meeting rooms located in the new wing.

Industrial and scientific exhibits also will be housed in the beautiful and spacious Exhibit Center in the new West Virginia Wing.

Additional information concerning the convention at The Greenbrier will appear in future issues of *The Journal*. The complete program will appear in the issue for August.

Make Your Reservation Now!

Members of the West Virginia State Medical Association are urged to make reservations without delay for accommodations during the 95th Annual Meeting at The Greenbrier in White Sulphur Springs, August 23-25, 1962. Application forms for room reservations were enclosed in a bulletin mailed to each member last month. The completed forms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, West Virginia.

Physician's Guide on Anticoagulants Issued by Heart Association

A new booklet has been published by the American Heart Association which provides physicians with guiding principles and practical recommendations for the use of anticoagulant drugs.

Entitled "A Guide to Anticoagulant Therapy," the booklet contains material designed to aid the physician who has decided to institute anticoagulant therapy in making the most effective use of these drugs. It does not consider the indications for therapy or the merits of different agents in the prophylaxis or treatment of specific diseases.

The two types of agents currently employed, Heparin and Coumarin-type compounds, are discussed with reference to their physiologic effects, administration, contraindications and appropriate antidotes.

The publication emphasizes the importance of individualized treatment, careful clinical observation, and frequent reliable laboratory tests. In addition, many common problems of anticoagulant therapy are discussed in question and answer form. The booklet also contains several tables and selected references.

Physicians may obtain copies of the booklet by writing the West Virginia Heart Association, Box 5336, Capitol Station, Charleston, West Virginia.

American College of Physicians Meeting in Philadelphia

More than five thousand physicians are expected to attend the 43rd annual meeting of the American College of Physicians in Philadelphia, April 9-13. The scientific sessions will be held in Convention Hall and the headquarters hotel will be the Bellevue-Stratford.

Dr. Edward C. Rosenow, Jr., Executive Director of the ACP, said that the scientific program will include such diversified medical postgraduate activities as clinical investigation sessions, taking up newer discoveries in the basic sciences and clinical medicine, and daily hospital clinics featuring a review of current methods of diagnosis and treatment.

Three physicians have been nominated to receive awards during the meeting: Drs. Irvine H. Page of Cleveland, Ohio, Joseph Stokes, Jr., of Philadelphia, and William S. Middleton of Washington, D. C. They will present lectures as well as receive awards at the annual convocation.

Dr. Franklin M. Hanger of Staunton, Virginia, will be installed as president during the meeting, succeeding Dr. Chester M. Jones of Boston.

Medical Meetings, 1962

The following is a partial list of national, state and district medical meetings scheduled for 1962:

Apr. 9-12—AAGP, Las Vegas, Nevada.
Apr. 23-25—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
May 25-27—W. Va. Chap. AAGP, Charleston.
June 6-8—W. Va. PH Association, Huntington.
June 24-28—AMA Annual Meeting, Chicago.
June 28-29—Seminar on "The Adolescent," WVU Medical Center, Morgantown.
Aug. 16-18—W. Va. Hospital Assn., White Sul. Springs.
Aug. 23-25—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 13-16—PG Institute, Martinsburg.
Sept. 20-21—W. Va. Heart Assn., Morgantown.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.

Referral of Patients Requested

Physicians have been requested to cooperate in a study of chronic myelogenous leukemia being conducted by the Chemotherapy Service of the National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

Referrals of patients with chronic myelogenous leukemia are needed including some treatment refractory patients with high white blood cell and platelet counts, for studies of newer chemotherapeutic agents and as a source of white cells and platelets for *in vitro* and *in vivo* study. Accepted patients will be hospitalized for approximately eight to twelve weeks.

Further information may be obtained by contacting Dr. Paul P. Carbone, Chemotherapy Service, National Cancer Institute, Bethesda 14, Maryland.

Medical Emergencies Committee Meeting in Charleston

The responsibilities of the medical profession in the Emergency Health Service activities of the Civil Defense Program were outlined in detail during a meeting of the Medical Emergencies and Civil Defense Committee in Charleston on January 4.

Dr. John A. B. Holt of Charleston, the chairman, presided at the meeting which was attended by physician members of the committee and representatives of the State Department of Health.

Doctor Holt was directed to prepare the following report to be mailed to secretaries of component societies throughout the state:

The responsibility of the medical profession in the Emergency Health Service activities of the Civil Defense Program can be generally stated to fall into four broad areas:

1. Casualty care of sick and injured.
2. Promoting and offering Expanded Function Training to para-medical groups.
3. Promoting, sponsoring and supervising emergency hospital plans for existing facilities and for use of the stock-piled 200-bed Civil Defense Emergency Hospitals.
4. Sponsoring and supplying medical supervision to the Medical Self-Help Training Program.

Preparation for function in the care of the sick and injured can be obtained by acquainting ourselves with the potential conditions that might exist in a disaster situation, availing ourselves of supplemental and refresher courses, seminars and conferences on the subject, and maintaining our basic knowledge, skills and techniques for utilization in austere conditions and circumstances.

In widespread disaster situations with the potentiality of serious decrease in the present medically trained personnel, we will have to depend on para-medical groups for assistance in the care of the sick and injured to an extent to which we nor they are accustomed. We are solely responsible for this Expanded Function training and for setting up and carrying on a program to maintain their up-graded skills and techniques.

Every hospital and clinic must have an emergency plan for operation in disaster situations. These plans, to be effective, must be continuously practiced and revised. Every physician having any contact with any medical care facility must assume a personal responsibility for this.

There are ten 200-bed Civil Defense Emergency Hospitals stored in West Virginia as part of the National Medical Stockpile and according to allocation formula we should have twelve additional when adequate protected storage can be located and secured. An additional Civil Defense Emergency Hospital has been assigned to the State for training purposes and is under the supervision of the State Department of Health. The State Department of Health has readied this unit for training and has sponsored one exercise for its own staff. It is now available for any group to use for training exercises at its permanent site in the Health Department's facility, or it may be transported to any other site. Other states are requesting additional training units and if we fail to use the one assigned to us, it is quite probable that we will lose it. In a disaster situation one of these stockpiled units may be the only medical facility containing all the medical supplies and equipment available for several days. It is of the utmost importance that we have knowledge of the limitations that may be thrust upon us and that we see to it that there are trained teams in our com-

Dr. John A. B. Holt of Charleston, chairman of the Medical Emergencies and Civil Defense Committee, exhibits a Medical Self-Help Training Kit at a meeting of the committee held in Charleston on January 4. Seated around the table are, left to right, Dr. L. P. Hudnall of Wheeling, Dr. A. L. Dickerson of Charleston, Dr. E. L. Linger of Clarksburg, Dr. Charles T. Lively of Weston, Dr. George Miyakawa of Charleston, Mr. Samuel J. Hawkins of Charleston and Dr. M. D. Reiter of Wheeling.

munities which can set up this facility and put it into operation as efficiently as possible.

Getting information to the total population of the State which will enable the average citizen to practice health preservation and actually perform life-saving measures which are ordinarily accomplished by a physician is of utmost importance. This Medical Self-Help Training Program has the approval of the American Medical Association, the Public Health Service and the Medical Services of the Armed Forces. It is your responsibility to see that the people in your community have the opportunity to take this course and that the medical aspects of it are presented by qualified instructors and under the sponsorship of a physician.

The Committee of the State Medical Association on Medical Emergencies and Civil Defense, at its recent meeting recommended and urged that each component society have a comparable *functioning* committee and that some phase of the physician's responsibility in planning for Emergency Health Services be a part of each meeting of the Society.

136-Million Persons Protected By Health Insurance

In 1961, the health insurance business reached new highs both in the number of persons covered and in the amount of benefits paid out, the Health Insurance Institute reported recently in a review of the past year.

The Institute estimated that as of Dec. 31, 1961, some 136 million persons—or 75 per cent of the civilian population—were protected by some form of health insurance, an increase of four million over the record figure of 132 million reached in 1960.

The Institute also estimated that benefit payments during 1961 totaled $6.3 billion, an increase of about 11 per cent over the record $5.7 billion paid out in 1960.

Another important development during 1961 was the swift expansion of health insurance coverage among older people. In addition to the 136 million protected against the cost of hospital care at the end of last year, it was estimated that 124 million persons had surgical expense insurance, 91 million had regular medical expense insurance, 35 million had major medical insurance provided by insurance companies, and 43 million had loss of income protection.

Increase in Blue Shield Enrollment

Enrollment in the nationwide Blue Shield plans passed the 48,400,000 mark as of September 30, 1961, according to a recent announcement by the National Association of Blue Shield Plans. Total membership in the 75 medical-surgical Blue Shield Plans amounted to 48,415,337, as a result of a net gain of 1,330,349 new members during the first nine months of 1961.

The Association said, "Blue Shield now covers one out of every four Americans, and almost 15 per cent of the total Canadian population." Thirteen Blue Shield plans have enrolled more than 40 per cent of the population in the areas they serve.

Another $500 Contribution To Scholarships Fund

Mr. Harry H. Carnahan, President of The Medical Arts Supply Company in Huntington, has made a contribution of $500 to The Charles Lively Memorial Scholarships Fund of the West Virginia State Medical Association. This is the fourth successive year that Mr. Carnahan has contributed the sum of $500 to the Scholarships Fund which is maintained by the Association.

Under the program which was established a few years ago, four students have already been awarded scholarships of $1,000 per annum each to the WVU School of Medicine. They are Larry Hemmings of Charleston, who will receive his M. D. degree in June; Terry Tallman of Alma, Tyler County, a junior; Glen Buchanan of Gilbert, Mingo County, a sophomore; and Clare D. Edman of Parkersburg, a member of the first-year class.

Dr. Russel Kessel of Charleston is Chairman of the Association's Committee on Medical Education, Hospitals and Scholarships.

ACP Course in Ann Arbor

The American College of Physicians will present a postgraduate course in "Gastroenterology: Basic Principles and Treatment" at the University of Michigan School of Medicine in Ann Arbor, March 5-9. The course is designed to emphasize basic underlying physiology and biochemistry as it relates to fundamental issues of the normal processes of the gastrointestinal tract, as well as to provide an understanding of the different disease processes.

Additional information may be obtained by writing Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania.

Frank E. Bunts PG Course

The Frank E. Bunts Educational Institute, affiliated with the Cleveland Clinic Foundation, will offer a postgraduate course in "Clinical Fundamentals of Liver Disease" in Cleveland, March 7-8.

Due to limitation of auditorium capacity, registration will be limited to 125. Additional information may be obtained by writing Dr. Charles L. Leedham, The Frank E. Bunts Educational Institute, 220 East 93rd Street, Cleveland 6, Ohio.

Relocations

Dr. C. W. Stallard, Jr., who practiced medicine in Fayette County for more than ten years, has moved to Calumet, Michigan, where he has accepted appointment as Medical Director of the Calumet and Hecla Corporation. His new mailing address is 305 Tamarack Street, Laurium, Michigan.

New Association Members

Dr. James Kermit Sexton, 313 12th Street, Dunbar (Kanawha). Doctor Sexton, a native of Elkhorn City, Kentucky, was graduated from the University of Kentucky and received his M. D. degree from the Bowman-Gray School of Medicine of Wake Forest College in 1959. He interned at Charleston Memorial Hospital, 1959-60, and was licensed to practice in West Virginia in 1961. He is engaged in general practice.

* * * *

Dr. Robert H. Skaff, Poca (Kanawha). Doctor Skaff was born in Detroit, Michigan, and attended the two-year School of Medicine at West Virginia University. He received his M. D. degree from the George Washington University School of Medicine in 1958 and served an internship at Providence Hospital in Washington, D. C., 1958-59. He was licensed to practice in West Virginia in 1961, following two years service as a commissioned officer with the United States Public Health Service.

* * * *

Dr. Shen K. Wang, 206 Bethlehem Building, Fairmont (Marion). Doctor Wang, a native of China, was graduated from National Central University in China. He received his M. D. degree from Harvard Medical School and served an internship at St. Mary's Hospital in Madison, Wisconsin. He took residency training at Massachusetts General Hospital and Children's Hospital in Boston. His specialty is orthopedic surgery.

* * * *

Dr. Charles C. Weise, 501 Atlas Building, Charleston (Kanawha). Doctor Weise, a native of Marmet, was graduated from West Virginia University and received his M.D. degree from the University of Pennsylvania School of Medicine in 1955. He interned and served a residency at the Philadelphia General Hospital. He served as a Captain in the Medical Corps of the United States Army and was licensed to practice in West Virginia in 1961. His specialty is psychiatry.

New Film on Medical Genetics

The National Foundation has announced that a new teaching film, "Medical Genetics—Part II," is now available for showings before county medical societies and other interested medical groups. The film was prepared by Dr. Victor A. McKusick and associates in the Division of Medical Genetics at the Johns Hopkins University School of Medicine.

The film may be obtained free of charge, except for return postage and insurance, by writing the Department of Professional Education, The National Foundation, 800 Second Avenue, New York 17, N. Y.

PG Institute in Philadelphia

Dr. Edward R. Annis of Miami, Florida, will be among the speakers at the Philadelphia County Medical Society's 26th annual Postgraduate Institute at the Bellevue-Stratford Hotel in Philadelphia, March 13-16.

Further information concerning the meeting may be obtained by writing Dr. Malcolm W. Miller, 301 South 21st Street, Philadelphia 3, Pennsylvania.

1962 National Chamber Aircade In Charleston on March 2

Physicians in West Virginia have been extended a cordial invitation to attend the "1962 Aircade for Citizenship Action" which will be held at the Civic Center in Charleston on March 2. The meeting will be sponsored by the Chamber of Commerce of the United States in cooperation with the local and state organizations.

Charleston is one of 15 cities in the United States selected for the one-day session, which is expected to attract more than 800 persons from West Virginia and neighboring states. The meeting will begin at 9:30 A.M. and will be adjourned at 3:30 P.M.

Richard Wagner, president of the National Chamber, will head the Aircade team which will conduct meetings in 15 cities within the limited span of 19 days, starting February 26. The fast-moving schedule has been set to follow closely the opening of the Second Session of the 87th Congress, and to come after the delivery and evaluation of the President's State of the Union and other vitally important White House messages.

The following is a description of the program which will be presented, as outlined in a brochure issued by the National Chamber:

Key words—*Citizenship Action*—reflect the basic purpose and intent of the meetings—to stimulate greater citizenship action on major national issues before Congress, and the nation.

These are not ordinary meetings marked by stiff, dull lectures. Aircade meetings minimize speech-making. They are built around maximum audience participation. They concentrate on giving answers to questions asked by you from the floor.

Panelists of issue experts respond with rapid fire replies to questions you submit. The panels are made up from the Aircade team whose members are authorities on specific legislative subjects.

You will derive four things by attending an Aircade meeting:

1. You will get an intimate, meaningful picture of what is happening in Congress.
2. You will be armed with solid background information about current bills, about Congressional and White House strategems, and how these proposals and movements will affect you and the economy.
3. You will learn how to work more closely with your Congressmen and Senators so you can make your informed views heard and felt more effectively in Washington; and—
4. You will be shown how your actions as a citizen can build impact on the national scene.

By attending the Aircade meeting of your choice, you will become better informed, better prepared to act as an American citizen.

The morning and afternoon sessions will be held in the theatre at the Civic Center and luncheon will also be served. There will be a registration fee to cover the cost of the program and luncheon.

Additional information may be obtained by writing Mr. Charles E. Hodges, Managing Director, Charleston Chamber of Commerce, P. O. Box 471, Charleston 22.

Hospital and Blue Cross Assns. Oppose Passage of HR 4222

Meeting in Chicago, January 3-4, 1962, the House of Delegates of the American Hospital Association and the policy body of the Blue Cross Association went squarely on record in opposition to the passage of HR 4222, the King-Anderson proposal for providing health care for the aged under the Social Security mechanism.

The six paragraph statement passed by both groups endorses the Kerr-Mills approach to financing health care for the needy aged over-65, but advocated "realistic and equitable programs in every state" and further stipulated that "more attention must be placed on adequate reimbursement to participating hospitals and other health care institutions."

The action came after an intensive and exhaustive study of the problem directed by the AHA House of Delegates last September, under the direction of Walter J. McNerny, president of the Blue Cross Association and previously professor of hospital administration at the University of Michigan.

The heart of the statement is in paragraph two, where it is proposed that Blue Cross offer a national program for "a voluntary non-profit plan available to all persons aged 65 years and over." The basics of such a plan would possibly include 70 days of hospitalization, outpatient coverage, nursing home, rehabilitation and visiting nurse care, the latter on an increasing scale based on the benefits available under the national hospital inpatient plan.

Text of Statement

The entire text of the statement adopted by the two groups follows:

"1. We reaffirm the crucial need to continue vigorous efforts to foster realistic and equitable programs in every state for the adequate health protection of the indigent and medically indigent under a mechanism similar to the Kerr-Mills Act. (It was understood that to improve the effectiveness of state programs under the Kerr-Mills Act more attention must be placed on adequate reimbursement to participating hospitals and other health care institutions.)

"2. We recommend the earliest possible implementation of a national Blue Cross program for a voluntary non-profit plan available to all persons aged 65 years and over.

"3. We recognize that government assistance is necessary to effectively implement this national Blue Cross proposal in order to enable many retired aged persons to purchase this health protection through the voluntary prepayment system. Conditional upon the administration of this proposed plan by the voluntary nonprofit prepayment system, the tax source of the funds is of secondary importance to us.

(The last sentence of the above statement was interpreted to mean that the source of funds is of secondary importance to us provided the proposed plan is administered by the voluntary nonprofit prepayment system and not by the Social Security Administration.)

"4. The individual aged person should receive governmental financial assistance on a decreasing scale related to income, the low income person to receive major or even total assistance and the higher income person to receive less. The determination for government assistance should be made in accordance with current income reported for federal income tax purposes or, if this is not possible, some legally acceptable declaration of income. The determination should not be made in accordance with the usual means test determinations made under public welfare programs.

"5. We emphasize the urgency and importance of planning for the provision of adequate facilities and personnel in order that skills and services may be available to render high quality care to the aged.

"6. It is the sense of this meeting of the House of Delegates of the American Hospital Association that the best interests of the retired aged will not be served by passage of the King-Anderson bill. Our opposition to this bill is based upon careful study of the needs of the retired aged and the overall economic effect of such a program. We believe that the retired aged will be better served by a program such as has been proposed by Blue Cross plans."

The House of Delegates also approved the revised Principles of Payment for Hospital Care and referred to the Board of Trustees with power to act additional suggestions for revisions in the Principles that were proposed by the Delegates' Review Committee assigned to study and report on this document. The Board of Trustees referred these suggestions to the Council on Blue Cross, Financing and Prepayment for consideration and recommendations.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston 24, West Virginia.

New AMA Health Director

Fred V. Hein, Ph.D., has been appointed Director of the Department of Health Education of the American Medical Association. He assumed his new duties last month.

He succeeds Dr. W. W. Bauer, who has served as Director of the Department since 1932. Doctor Bauer has been named Director Emeritus and will be assigned to the staff of the Division Director.

Unknown Prescriptions

The thrust of invention and development has placed us all in an informational pressure cooker, and nowhere is this fact more clinically apparent than in the field of medicine.

I am told by a doctor friend that seven out of ten prescriptions written today are for items unknown to medicine before World War II. The communications problems that result are more serious here than in any other area, since human health and life itself are involved.—David Sarnoff, to National Health Council.

What people say behind your back is your standing in the community in which you live.—E. W. Howe.

Sharp Increase in New Cases Of Infectious Hepatitis

Although new cases of infectious hepatitis dipped sharply during the last week of 1961, the State Health Department recorded a sharp upsurge in the disease during the first week of the new year.

State Health Director N. H. Dyer said only 13 cases were listed for the week ending December 30. By the end of the following week, however, 47 additional cases had been reported. Commenting in the "State of the State's Health," a weekly publication of the department, the health director noted that West Virginia had 1,611 cases during 1961, the highest total for any year on record.

He said it was too early to determine "whether or not the worst is behind us in the current epidemic" and urged a continuation in efforts to immunize intimate household with immune gamma globulin and prompt reporting of new cases as a means of controlling the disease.

Even though estimates indicate that supplies of gamma globulin available for free distribution by the State Hygienic Laboratory will not meet half the need, Doctor Dyer said distribution would be continued through local health officials until the inventory was exhausted. He urged physicians, however, to obtain gamma globulin from commercial supplies if families can afford the expense.

Polio Vaccine

In another issue of the publication, Doctor Dyer explained an official policy statement regarding the usage of live poliomyelitis vaccine which was promulgated recently by the health department.

He discouraged usage of the live vaccine for individual vaccinations until such time as it was available for immunization against all three types of the virus.

"Although the Public Health Service has licensed for manufacture the live poliomyelitis vaccine for types I and II of the disease, manufacturing difficulties still remain to be solved before type III vaccine production can be taken out of the laboratory and produced in quantity," he explained.

Doctor Dyer observed that the Salk vaccine has proved 90 to 95 per cent effective in prevention of paralysis due to poliomyelitis, when the full course of four injections has been given. Also that increased potency of the vaccine during 1961 and continued improvement of the product may result in a vaccine of nearly 100 per cent efficacy.

He noted also that the national disease trends indicate an increase of approximately 35 per cent in type I morbidity over the previous year when nearly 90 per cent of all reported cases were due to type I virus.

Influenza-Like Diseases

Turning to reported outbreaks of influenza-like diseases in other states, Doctor Dyer said that epidemics in Florida, Colorado, Arizona and California had been confirmed as type B, of moderate severity.

While the incidence of influenza-like diseases in West Virginia continues about normal for the winter months, he emphasized the possibility of a potential epidemic situation because of the outbreaks in other areas.

A previously reported shortage of influenza vaccine had not improved by late in December, at which time the health department polled a number of health officers in larger areas in the state. He said that manufacturers had produced three times the amount in 1961 as compared to the previous year but production could not keep up with the demand. Consequently, he urged that until the inventory situation improved immunization should be continued to individuals of the high risk groups or other cases where protection is considered advisable by physicians.

Dr. Irvine H. Page To Speak In Charleston on Feb. 7

Dr. Irvine H. Page of Cleveland will be the guest speaker at a special Public Health Forum which will be held at the Civic Center in Charleston on February 7, beginning at 8 P.M. The evening meeting will be sponsored by the Kanawha Valley Heart Association, an affiliate of the West Virginia Heart Association.

Doctor Page, who is Director of Research and a member of the Governing Board at the Cleveland Clinic Foundation, will present a paper on "You and Your Heart."

A native of Indianapolis, Indiana, he received his M.D. degree from Cornell University Medical College in New York City in 1926. He has been engaged in research work at various institutions since that time.

He is the author of several books and currently is serving as Editor-in-Chief of *Modern Medicine*. He is a past president of the American Heart Association.

Physicians are cordially invited to attend the meeting and further information may be obtained by writing Mrs. Elsa S. Hines, Executive Secretary, Kanawha Valley Heart Association, 612 Virginia Street, E., Charleston 1, W. Va.

Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

Annual Meeting in Maryland

The 164th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland will be held at the Alcazar Hotel in Baltimore, Maryland, April 4-6, 1962.

Information concerning the scientific program may be obtained by writing Dr. Houston S. Everett, Chairman, Committee on Program and Arrangements, 1211 Cathedral Street, Baltimore 1, Maryland.

Heart Association Seeks Candidates To Study Research Methods

A fellowship program aimed at stimulating research in medical education has been established by the American Heart Association. "Undertaken in an effort to meet the need for specialists to guide and evaluate professional education activities at both the undergraduate and post-graduate level, the new program will seek to encourage clinical and/or basic scientists to study educational principles and methods of educational research," Dr. Morris H. O'Dell of Charleston, president of the West Virginia Heart Association, said recently.

Candidates selected will be given an opportunity to receive training at one of the three medical schools that have established departments of research in medical education. They also will take part in the investigative programs in which these groups are engaged and in the experimental pilot projects in continuing education now being established by the American Heart Association.

In order to meet the needs of candidates drawn from varied background and experience, no fixed fellowship stipend has been established. An appropriate level of support can be provided for candidates who have just completed residency training, or those who have already achieved the level of independent investigation.

Additional information may be obtained by writing the West Virginia Heart Association, Box 5336, Capitol Station, Charleston, W. Va.

Utilization of Hypnosis

The annual meeting of the American Society of Psychosomatic Dentistry and Medicine will be held at the Shoreham Hotel in Washington, D. C., March 2-4. The main theme of the program will be patient relationship, its importance and development in the clinical setting of general practice.

There will be several roundtable discussions concerning the utilization of hypnosis in the various specialties of general practice. Physicians and dentists in neighboring states have been invited to attend the three-day meeting.

Additional information concerning the program may be obtained by writing Dr. Jesse Caden, 5213 Connecticut Avenue, N. W., Washington 15, D. C.

Rhinologic Society Course in Milwaukee

An introductory course on "Expanded Surgery of the Nasal Septum and Closely Related Structures" will be presented by the American Rhinologic Society at the St. Michael Hospital in Milwaukee, Wisconsin, March 16-19.

Dr. Maurice H. Cottle, professor of otorhinolaryngology at the Chicago Medical School, will be the guest director. The course will consist of lectures, laboratory and surgical demonstrations.

The registration fee for the four-day meeting will be $150. Additional information may be obtained by writing the American Rhinologic Society, 530 Hawthorn Place, Chicago 13, Illinois.

Who is Blue Shield, Anyway?

We frequently hear one or another of our colleagues refer to his Blue Shield plan as though it were some kind of foreign power. "How come that Blue Shield plan won't pay for an incidental appendectomy?" he'll ask, with something of the same mixture of detached resentment and impotent impatience he would exhibit if he were commenting on a new provocation by Fidel Castro.

But Blue Shield is us—the medical profession. In the beginning, it became a member of the medical family either by birth or by legal adoption, since every Blue Shield plan was organized by its local medical society, or at least with its explicit approval. Blue Shield is a member of our family because it is subject to our discipline. Its medical policies are guided by medical men and by the medical societies whose endorsement every Blue Shield plan must maintain.

Moreover, like our profession itself, Blue Shield's sole motivation is to help us better to serve our patients. Like us, Blue Shield seeks to help the whole community—not just the fortunate few who least need medical care or are best able to pay for it—or both.

Perhaps most important, Blue Shield seeks, as an ideal, to help us render our services at a predictable cost, particularly for our patients in the medium and lower income brackets. This is the true meaning of the service benefit commitment which nine out of ten of us have accepted in four out of five of all Blue Shield Plans. Even in those areas where our colleagues have not made a formal commitment to render fully paid service, Blue Shield is seeking to provide schedules of payment that will be acceptable to us on that basis.

Blue Shield is a shield of comfort and security for our patients. And for us, it is something we have created to help us meet our community responsibilities. Blue Shield is a bridge between us and our patients—and a strong shield for the preservation of freedom in the practice of medicine.

The Brand Name Is Here to Stay

I think I am safe in assuming that we do not want socialized medicine, or state medicine, any more than we want to do away with our American system of free enterprise. If this be true, then I can assure you that the brand name, or trademark, is here to stay.

If you will stop to think about it a moment, you will recognize that our entire system of free enterprise is, in fact, based on brand names. Brand names enable the consumer to reward the product which is proved to be good—and the reward comes through repurchases of the product.

If a product proves to be unsatisfactory, the consumer has the means of punishing it—by refusing to buy it again. And the means is, of course, his ability to identify the unworthy product through the trademark or brand name.—Theodore G. Klumpp, M. D.

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New PRO-BANTHĪNE P.A. will be of particular benefit in controlling acid secretion, pain and discomfort both day and night in ulcer patients and in inhibiting excess acidity and motility in patients with peptic ulcer, gastritis, pylorospasm, biliary dyskinesia and functional gastrointestinal disorders.

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WVU Medical Center
–News–

• **Compiled from material furnished by Cletis Pride, Public Information Officer, West Virginia University Medical Center, Morgantown, W. Va.**

THE Department of Psychiatry has been activated at the West Virginia University School of Medicine. Teaching and clinical services will be centered in a 28-bed in-patient service in the Medical Center and an extensive out-patient department serving physicians throughout the state.

Dr. Thomas A. Loftus, who was formerly Associate Professor of Psychiatry at Jefferson Medical College, is Professor and Chairman of the Department.

Other members of the staff are Dr. Charles E. Goshen, former director of community psychiatric services for the State of Maryland, and Dr. Robert Vosburg, currently with the Western Psychiatric Institute and Clinic in Pittsburgh.

New Member of Radiology Staff

Dr. John D. H. Wilson of Clarksburg recently accepted appointment as clinical associate professor in the Department of Radiology in the School of Medicine. He will serve at the VA Hospital in Clarksburg, which works with the University as a Dean's Committee Hospital.

Doctor Wilson, a native of Clarksburg, received his M. D. degree at the Johns Hopkins University School of Medicine. He served his internship and an assistant residency in surgery at Boston City Hospital and his residency in radiology and a fellowship in radiation therapy at Jefferson Medical College Hospital in Philadelphia.

He is certified by the American Board of Radiology and is a member of the American College of Radiology and Radiological Society of North America. He is a member of the Harrison County Medical Society, the West Virginia State Medical Association and the American Medical Association.

23 Students Receive Scholarships

Twenty-three students in the School of Medicine were among sixty students receiving graduate scholarships awarded by the WVU Board of Governors during the current academic year.

Each scholarship entitles the recipient to waiver of such enrollment, tuition, registration and other fees as may be prescribed by the Board of Governors.

Recipients of the scholarships are as follows:

First-year class: Eugene R. Dorsey, Huntington; Linda D. Lewis, Beech Bottom; Sally L. Taylor, Alloy; Edward H. Thompson, Williamson; Harvey D. Reisenweber, Baltimore, Maryland; and Norman P. Silvers, Flushing, New York.

Second-year class: Richard H. Garretson and David R. Hobbs, Morgantown; David M. Bear, Fairmont; Thomas O. Dotson, Summersville; Louis A. Fabian, Monongah; and John A. Karnoupakis, Weirton.

Third-year class: John Lee Fullmer, Reedsville; Robert F. Gustke, Parkersburg; Lowell T. Mouser, Minnehaha Springs; Jack Pushkin, Charleston; Richard D. Richmond, Beckley; and Donald R. Swartz, Morgantown.

Fourth-year class: Francis A. Goad, Clendenin; Ira L. Hemmings, St. Marys; Charles W. Lewis, Huntington; Joseph Ruggiero, Fairmont; and George H. Nelson, Charleston, South Carolina.

Research Grants

The School of Medicine has been granted $25,000 by the National Institutes of Health to continue the School's undergraduate training in cardiovascular disease during 1962.

The grant will be used to buy equipment and supplies and to employ part-time clinical instructors necessary to the program. Dr. Edmund B. Flink, Professor and Chairman of the Department of Medicine, is director of the training program.

Dean Clark K. Sleeth said the NIH has allocated $25,000 a year through 1966 for support of the program.

A $13,769 grant for research on the relationship of oral arteriosclerosis to age has been awarded the University by the National Institutes of Health.

The three-year project is under the direction of Dr. Edward G. Stuart, Associate Professor of Pathology in the School of Medicine, and Dr. Elmer E. Kellin, Associate Professor of Oral Pathology in the School of Dentistry.

A grant totaling $36,008 was recently awarded to the University by the National Institutes of Health to support a three-year study of how lipids pass from the intestine to the blood stream. Dr. Reginald F. Krause, Professor and Chairman of the Department of Biochemistry, and Dr. Damon C. Shelton, Associate Professor, are in charge of the investigation.

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3 Does not muddle the mind or affect normal behavior

The Month in Washington

• From the Washington Office of the American Medical Association.

REPORTS by the American Medical Association and the Health, Education and Welfare Department showed that 38 states have taken advantage of the Kerr-Mills law providing medical care for the aged with a total expenditure of $121 million in the first 15 months of the program.

Citing the program's wide acceptance, Dr. Leonard W. Larson, president of the AMA, said that 27 states had enacted Kerr-Mills Medical Assistance to the Aged (MAA) programs and 11 other states had expanded Old Age Assistance (OAA) medical benefits under the new law.

In addition, he said, nine states already had OAA medical programs on the books and in most instances they are considered to be adequate to provide the necessary health care for those over 65. Two of the three remaining states—Arizona and Delaware—have excellent assistance programs at the local level which include medical care, Doctor Larson said.

Kerr-Mills Widely Accepted

"These figures certainly contradict statements by Kerr-Mills critics who say that the program can't and won't work," Doctor Larson said.

"In just 15 short months Kerr-Mills has been widely accepted across the land and with each passing day is proving that it can, and if given the fullest opportunity, will do the job.

"Kerr-Mills is being implemented by the states as fast if not faster, than any previous federal-state matching program.

"Such rapid acceptance of this principle makes any compulsory health program through the social security mechanism totally unnecessary."

Under the Hill-Burton program, 535 hospitals, nursing homes, rehabilitation centers, and other facilities were awarded $146,330,000 in Federal funds toward $468,661,000 of construction in 1961.

Drug Legislation

Manufacturers accepted a congressional proposal for further government controls over the efficacy of prescription drugs, but stood pat in opposing patent provisions of the controversial drug legislation sponsored by Sen. Estes Kefauver (D. Tenn.).

Eugene N. Beesley, chairman of the Board of the Pharmaceutical Manufacturers Association, said that the PMA "fully endorses the principle that a drug should be effective for the uses that a manufacturer claims for it; and, second, that the Food and Drug Administration, in passing on new drug applications to determine the safety of the new product, already evaluates—in many cases—the evidence of its effectiveness for the uses claimed."

"Since FDA has expressed a desire to have its authority clarified with respect to its consideration of the effectiveness as well as the safety of new drugs, we wish to support the proposal as we understand it," he added.

Mr. Beesley said such FDA clearance "would assure physicians that a drug effectively produces certain physiological actions; but the physician, not the FDA, would determine whether these specific physiological effects would be useful or beneficial with respect to particular patients."

Proposed Patent Restrictions

Mr. Beesley said the patent restriction proposed in the bill "would virtually destroy the patent system with respect to medicines."

"This proposal obviously strikes directly and crucially at the industry's capacity and incentive for discovery of new and improved medicines, and we vigorously oppose it," he said.

Senator Kefauver indicated he might compromise on the patent provision, saying that he was "not irrevocably wedded to the precise approach" of his legislation.

Senator Kefauver endorsed AMA's expanded drug information program which will put the data directly in the hands of prescribing physicians in contrast to new FDA regulations which place the emphasis on distribution of new drug information to pharmacists.

"The PMA is supporting and, I trust, will continue to support the new and broadened program it has established with the American Medical Association of disseminating to physicians better and more accurate information concerning the bad as well as the good features of drugs," Senator Kefauver said.

"And it is supporting, and again I trust will continue to support, the new program of the U.S. Pharmacopoeia and the AMA in establishing simpler and more usable generic names for drugs.

"These are important steps forward."

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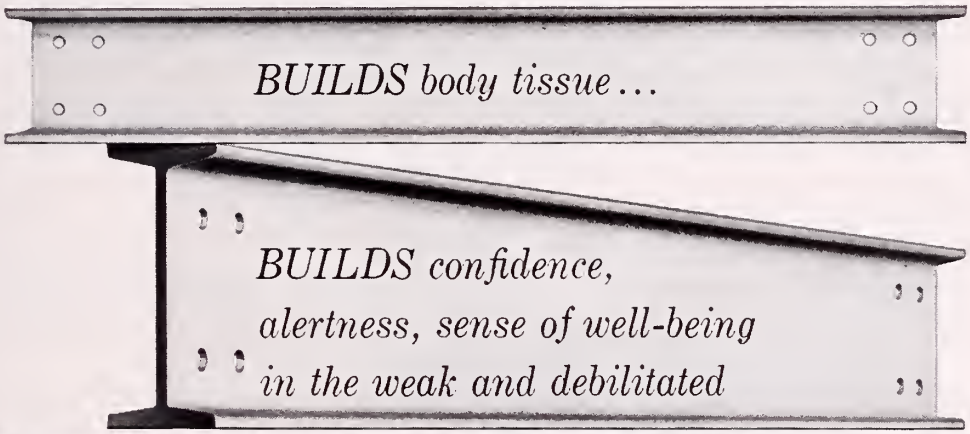

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...the patient on prolonged steroid therapy—to counteract catabolic effects

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*animal data

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Obituaries

RUSSELL SMITH COFFINDAFFER, M. D.

Dr. Russell Smith Coffindaffer, 66, who practiced medicine for more than thirty years in Shinnston, died at the home of his daughter in St. Albans on December 24.

Doctor Coffindaffer was born at Kincheloe, Harrison County, on March 5, 1895, son of Abraham B. and Josephine Carder Coffindaffer. He was graduated from Salem College and the two-year School of Medicine at West Virginia University. He received his M. D. degree in 1925 from the Medical College of Virginia and was licensed to practice medicine in West Virginia that same year.

He interned and served a residency at Bellevue Hospital in New York City, 1925-27. He located in Shinnston at the completion of his training.

Doctor Coffindaffer was a Fellow of the American College of Surgeons and a member of the Harrison County Medical Society, West Virginia State Medical Association, Southern Medical Association and American Medical Association.

Besides his widow, he is survived by a daughter, Mrs. Charles Jackson of St. Albans; a brother, Ernest W. Coffindaffer of Clarksburg; a sister, Mrs. Tilman Williams of Bristol; and three grandchildren.

JOHN PIERPONT HELMICK, M. D.

Dr. John Pierpont Helmick, 57, of Fairmont, died on December 10 at his winter home in Monroe, Louisiana.

Doctor Helmick, who practiced his specialty of internal medicine in Fairmont for more than 25 years until his retirement several years ago, was born in that city on November 18, 1904, son of the late Ernest and Hermione Pierpont Helmick.

He was graduated from West Virginia University and received his M. D. degree from Jefferson Medical College in 1930. He interned and served a residency at the Jefferson Medical College Hospital. He was licensed to practice in West Virginia in 1932 and located in Fairmont that same year.

He served terms as secretary and president of the Marion County Medical Society, and also served two terms as a member of the Council of the West Virginia State Medical Association. He was an honorary life member of the county, state and American Medical Associations, and a Fellow of the American College of Physicians and the American College of Chest Physicians.

His widow, Mrs. Clare Dean Johnson Helmick, is a past president of the Woman's Auxiliary to the State Medical Association.

He is also survived by two sons, Lt. John P. Helmick, II, stationed with the United States Navy at Jacksonville, Florida; a daughter, Mrs. Howard D. Hayes, Jr., of Arlington, Virginia; and five grandchildren.

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RITCHIE ALEXANDER IRELAND, M. D.

Dr. Ritchie Alexander Ireland, 77, of Charleston, died on December 14 at a hospital in that city following a short illness.

Doctor Ireland served as City Health Commissioner in Charleston from 1919 to 1923 and in 1957 accepted an interim appointment as Director of the Kanawha-Charleston Health Department. He was a member of the Medical Appeal Board in West Virginia's Sixth District during World War I.

Doctor Ireland, who was a native of White Oak, Ritchie County, was born on October 1, 1884, son of the late George M. and Mary Law Ireland. He attended West Virginia Wesleyan and West Virginia University, and received his M. D. degree from the University of Maryland School of Medicine in 1912. He was licensed to practice medicine in West Virginia in 1913 and located in Charleston that same year, where he practiced continuously until his recent illness.

He served a term as president of Kanawha Medical Society and the West Virginia Hospital Association. He was an honorary life member of the West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a son, James D. Ireland of Charleston; a sister, Mrs. Ella Hall of Harrisville; two brothers, P. M. Ireland of West Union and W. P. Ireland of Pullman; and four grandchildren.

BAYARD LEE LIGGETT, M. D.

Dr. Bayard Lee Liggett, 74, of Mill Creek, Randolph County, died at his home in that community on December 20 following a long illness.

Doctor Liggett was born in Braxton County on February 24, 1887, son of the late James Lloyd and Jamima Beamer Liggett. He attended West Virginia Wesleyan College and was graduated from the University of Maryland School of Medicine in 1914. He practiced in Mill Creek for two years prior to being commissioned as a first lieutenant in the Medical Corps of the United States Army. He served overseas for two years, being released in 1919 with the rank of Captain. He resumed practice at Mill Creek in 1920.

He served for almost fifty years as health officer in his community, and as physician for the Medium Security Prison at Huttonsville for twenty years. He was an honorary member of the Barbour-Randolph-Tucker Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a son, William H. Liggett of Pittsburgh; a brother Bassell E. Liggett of St. Albans; three sisters Mrs. John R. Sutton of Mill Creek, Mrs. Ernest Holden of Clarksburg, and Mrs. Charles Hutton of Parkersburg; and one grandchild.

* * * *

DONALD MONROE POST, M. D.

Dr. Donald Monroe Post, 65, of Morgantown, died on December 5 at his winter home in San Diego, California.

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Electrocardiography:
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Electroencephalography:
JaAnn Hastings
Roentgenology:
Evelyn Forester, R. T.

Business Administration:
John H. Clark, Manager
Lester L. Cline, Ass't. Bus. Mgr.

Doctor Post, who was engaged in practice in Morgantown until his retirement several years ago, was born in Spencer in 1896. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree from Jefferson Medical College in 1922. He was licensed to practice in West Virginia that same year and located in Morgantown.

During World War II, he served for three years with the Medical Corps of the United States Army. He was released from active duty in 1945.

He was an honorary life member of the Monongalia County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a son, Donald M. Post, Jr., of San Diego; and a sister, Mrs. Delbert S. Fisher of Parkersburg.

Rehabilitation

Since rehabilitation is an investment in the future for the patient and the community, and since it "adds life to years" even in the aging population group, the physician, therefore, is specifically urged to accept his responsibility for this type of care, as well as the care of the acute circumstances, in a more consistent manner than has been evident up to this time.

Rehabilitation is the third phase of medicine and is actually the "pay-off" for all the work that has gone before, during the acute phase of disease and injury, and can result in many instances in the return of the individual to a full productive life.—John C. Allen, M. D., in Connecticut Medicine.

The Cost of Diagnostic Tests

We are encouraged by the recent article in *Hospitals*, the official journal of the American Hospital Association, in which is described the new practice at Jefferson Medical College Hospital, Philadelphia, to teach students something of the overall costs of diagnostic tests.

In the report of William A. Sodeman, M. D., and John A. Nelson is told the system under which each student, as he works as a ward clerk, must maintain a running chart of costs on all tests and procedures on at least two of "his" patients. A glance at the chart reveals how total costs mount up and in group discussion the cost factors are analyzed in terms of balancing the benefits to the patients. The authors state, "The simple questions—'Do we need the test?' and 'Why?' are not to be disassociated from an understanding of the disease process, and the pathological physiology."

We can add only that a similar practice might well be instituted at other hospitals and not alone for medical students but for intern and resident physicians. The batteries of diagnostic tests which are so often ordered so glibly and unthinkingly and often—so it seems—to make the patient's chart look good in terms of "scientific" medicine, do indeed cost money. One can be all for scientific medicine but clinical acumen is not to be overlooked.—New York Medicine.

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County Societies

CABELL

A special business meeting of the Cabell County Medical Society was held at the Hotel Frederick in Huntington on December 19. Dr. C. Stafford Clay, the president, presided at the meeting which was attended by 48 members.

Discussion was confined to the current status of the Medical Aid for the Aged program, as outlined in Medical Services Letter No. 4 issued on November 28, 1961, by the West Virginia State Department of Welfare.

It was generally agreed that, until this matter can be further clarified, members of the Society shall resume their traditional and time-honored relationships with their patients.

The president was directed to appoint a committee to study the question, and to report back at the next meeting of the Society.

Dr. James A. Heckman was installed as president of the Cabell County Medical Society at the regular monthly meeting which was held at the Frederick Hotel in Huntington on January 11. He succeeds Dr. C. Stafford Clay.

Doctor Clay reviewed the work of the Society during the past year and praised particularly the efforts of the Public Service and Education Committees in effecting highly successful radio and TV publicity. He called for positive and determined resistance to all attempts to bring about socialized medicine and the welfare state.

Doctor Heckman acknowledged a contribution of $500 from Mr. Harry Carnahan of The Medical Arts Supply Company in Huntington to The Charles Lively Memorial Scholarship Fund.

Drs. Leopold Hernandez and William B. Whitaker were elected to membership in the Society.—W. L. Neal, M. D., Secretary.

* * * *

KANAWHA

The Council of the Kanawha Medical Society, at a special meeting held in Charleston on January 16, adopted a resolution embodying five major points. The purpose of the resolution is to clarify the Society's position in regard to medical care to the aged.

The resolution was prompted by a letter to the Society from Dr. A. C. Chandler. The five points of the resolution are as follows:

1. The Kanawha Medical Society reaffirms its sincere belief in the traditional practice of medicine; i.e., a doctor-patient relationship based on freedom of choice on the part of the patient and a dedication on the part

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of the doctor that no one, regardless of economic status, will be denied the services of a physician.

2. Recognizing that at times the costs of proper medical care became a burden, the Kanawha Medical Society endorses the principle of pre-paid hospital and medical insurance, particularly through the Blue Cross and Blue Shield plans.

3. The Kanawha Medical Society further recognizes the fact that some segments of the population are not able to provide even this type protection for themselves and their families, and that the State of West Virginia may have to provide it for them. However, it wishes to express its disapproval of the manner in which the State Department of Welfare has conducted the MAA Program.

4. It is therefore earnestly and respectfully recommended that the State of West Virginia follow the lead of such states as Texas and Washington and contract with Blue Cross and Blue Shield or some other actuarially sound insurance plan, to pay the group membership fees for those persons for whom it feels a responsibility to furnish medical and hospital care. This can be done under the Kerr-Mills Bill. By so doing the State will take itself out of the business of administering a medical welfare program and setting medical and hospital fees, functions which, under our American concept of government, rightly belong in the hands of citizen boards who have the interests of both the State and the individual at heart. The Society rejects the principle of state-set or federally-set medi-

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cal fees. Under this recommendation the question of fees would be the concern of the physician and the insurance carrier.

* * * *

MERCER

Eighty members and guests attended the annual Christmas Banquet of the Mercer County Medical Society which was held at the Bluefield Country Club in that city on December 18.

Dr. Henry F. Warden, Jr., the retiring president, presided at a business meeting which followed the banquet. New officers for the coming year were elected as follows:

Dr. Joe E. McCary, president; Dr. James E. McGee, Jr., vice president; and Dr. John J. Mahood, secretary-treasurer (reelected). Dr. Sam Milchin was named a member of the Board of Censors.

Drs. Wade H. St. Clair and Bernard S. Clements were elected to honorary life membership in the Society.—John J. Mahood, M.D., Secretary.

* * * *

MONONGALIA

Dr. C. Truman Thompson was elected president of the Monongalia County Medical Society during the regular monthly meeting which was held in Morgantown on December 5. Other new officers for the coming year are as follows:

Dr. C. A. Logue, vice president; Dr. George A. Curry, secretary; and Dr. John H. Trotter, treasurer. Dr. Carl E. Johnson was elected to a three-year term as a member of the Board of Censors.

Dr. J. C. Pickett, a member of the Council of the State Medical Association, presented a report on a meeting of that group held in Charleston on December 3. He answered several questions concerning recommendations made by the Council in connection with the Medical Assistance for the Aged Program.

The following members of the faculty of the WVU School of Medicine were elected to membership in the Society: Drs. William G. Klingberg, Byron M. Bloor, Barbara Jones, Charles E. Andrews and Rex B. Conn, Jr.—George A. Curry, M.D., Secretary.

* * * *

WYOMING

Dr. George F. Fordham of Mullens was elected president of the Wyoming County Medical Society during the regular quarterly meeting held at the Cow Shed in Pineville on December 10.

Dr. F. J. Zsoldos was elected vice president and Dr. Samuel D. Santa Rita was named secretary-treasurer.

Dr. Mario Cardenas, the retiring secretary, presided at the meeting in the absence of the president. Several members discussed the MAA and DPA programs and the Society voted to contribute $50 to the E. J. Van Liere Loan Fund.

Members of the Auxiliary were also present at the dinner meeting.—Samuel D. Santa Rita, M.D., Secretary.

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Corresponding Secretary: Mrs. Fred Moomau, Petersburg
Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

McDOWELL

Members of the Woman's Auxiliary to the McDowell County Medical Society were entertained by their husbands at the annual "Ladies Nite" which was held at the Gary Country Club on December 16. Dr. John H. Burke of Pageton served as chairman of the function, which was attended by more than 150 persons.

The first regular monthly meeting in 1962 was held at the home of Dr. and Mrs. Ray E. Burger in Welch on January 10.

The guest speaker was State Trooper J. N. White, who spoke on "Public Safety" and showed a film on the hazards of winter driving and how to cope with same. A question and answer period followed.

Mrs. Burger and Mrs. G. E. Irvin were in charge of arrangements for the luncheon meeting.—Mrs. F. L. Johnston, Secretary.

* * * *

MINGO

Wives of members of the Mingo County Medical Society were honor guests at the annual Christmas dinner which was held at the Mountaineer Hotel in Williamson.

The guest speaker was Dr. D. E. Greeneltch of Wheeling, President of the West Virginia State Medical Association. He gave an interesting talk on national and state legislation, with particular emphasis on the Medical Assistance for the Aged program in the State.

Following the dinner, Dr. and Mrs. A. H. Henderson entertained the physicians and their wives at their residence in South Williamson.

Dr. Robert J. Tchou was in charge of arrangements for the dinner meeting.—Mrs. Don V. Hatton.

Having an Opinion

A close friend said: "The first prerequisite for having a definite opinion on any subject whatsoever is to know nothing at all about the subject. The minute one begins to have knowledge of a field, he begins to equivocate, to have some diffidence in thinking and shows caution in expressing an opinion."—Journal of the Louisiana State Medical Society.

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Another element of raffishness in our largest city has joined the list of things beyond the pale. According to a board rule of the City of New York Board of Health, tattooing, except for medical reasons, has been banned from the City since November 1, 1961.

The tattoo parlors which nestled close to the Navy yard and the public dance halls must join burlesque and other colorful memories of civic adolescence in the sad skeleton closet of our past.

No longer may our youth in the first flush of love have the one's initials encircled by a heart placed permanently on his manly breast. No more will serpents writhe or dancers undulate as manly muscles ripple beneath the artist's fair creation.

And all because after two years of trial it proved impossible to indoctrinate the artists in sterile technic. With definite knowledge that a number of cases of infectious hepatitis were traceable to tattooing the Board of Health was forced to take drastic action.

The Board in its wisdom left an out, when it said "except for medical reasons." Shall some of us develop a side line of sterile, medical tattooing? The designs have limitless possibilities from the staff of Aesculapius to the formula for desoxyribonucleic acid.

Progress is inevitable, and we are for it, but being human we cannot avoid a fond look backward as we are swept along.—New York State Journal of Medicine.

We judge ourselves by what we feel capable of doing, while others judge us by what we have already done.—Henry Wadsworth Longfellow.

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Book Reviews

DIFFERENTIATION BETWEEN NORMAL AND ABNORMAL IN ELECTROCARDIOGRAPHY—By Ernst Simonson, M. D., Professor of Physiological Hygiene, University of Minnesota, Minneapolis; and Consultant in Electrocardiography at Mt. Sinai Hospital & Veterans Administration Hospital, Minneapolis. Pp. 328, with illustrations. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Missouri. 1961. Price $13.50.

As was aptly pointed out by Dr. Charles E. Kosman in the foreword of Doctor Simonson's book, "Since the initial communication by Lewis and Gilder on the normal electrocardiogram in man appeared in 1912, there have been many further attempts to define the limits of normality with greater precision." This opening statement literally summarizes the vast amount of work accumulated by Doctor Simonson in this book.

While this book differs from the usual presentation of electrocardiographic interpretation, it should by no means be limited to the specialist in this field. It should be acquired by anyone attempting to interpret electrocardiograms on a sound basis, both to be used as criteria to limit "over and under" interpretation.

The book does not deal with the electrophysiological manifestations or interpretation of various patterns on the electrocardiogram. It approaches this field in a manner different from other texts on electrocardiography. That is, what is the normal and abnormal variations noted on the ECG tracings and with what frequency should one expect these changes to occur. The data is substantiated by a wealth of appropriate investigative study as well as review of the literature in this field.

This book could be divided into two basic components: (1) The statistical validity of the criteria for abnormal and normal findings, and (2) How this data is applied clinically in the interpretation of the electrocardiogram. In addition, the author presents an excellent review of the stress tolerance tests and some aspects of spatial vectorcardiography.

This book has one time-consuming factor. That is, Doctor Simonson's more lengthy explanation for the derivation of statistical validity and how he arrived at his various findings. This material takes a great deal of time to interpret and, therefore, the reader is tempted to discount the amount of work such a book as this entails.

In the appendix, there are mean and standard deviations of Q,R.S,T amplitudes and normal limits for Q-T interval for ages 20 to 59. These tables should be readily available to any physician engaged in the analysis of electrocardiograms.

There is an excellent section which serves as a constant reminder on the sources of variability. These include technical changes, physiological variables, age, sex, body and chest builds, as well as race and electrical position.

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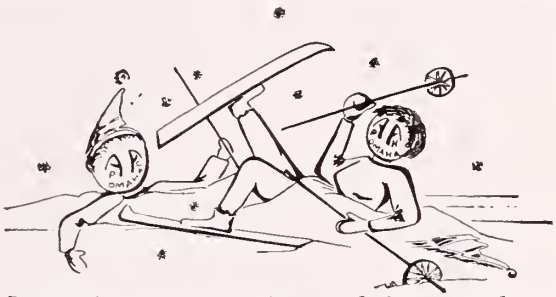

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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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This book, then, presents much needed data on electrocardiography in the adult patient, prepared in a useful manner, substantiated by adequate illustrations, graphs and tables.—James H. Getzen, M. D.

New Saunders Books

W. B. Saunders Company features the following recent books in their full-page advertisement appearing on page vii in this issue:

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THE STAGES OF HUMAN DEVELOPMENT BEFORE BIRTH —An Introduction to Human Embryology—By E. Blechschmidt, M. D., Professor of Anatomy, Director of the Institute of Anatomy, University of Gottingen. Pp. 684, with numerous illustrations. Philadelphia and London: W. B. Saunders Company. 1961. Price $23.

This large volume consists of a collection of drawings, photographs and photomicrographs of human embryos and fetuses from the fertilized ovum to the newborn. Many of the drawings depict reconstructions of different parts and organ systems. Most of the illustrations, especially the photomicrographs, are of good quality. Brief text descriptions accompany the illustrations. The first section of the book deals mainly with entire embryos at successive stages of development during the first three months of intrauterine life. The second section depicts organogenesis in different regions of the body.

Evaluation of this book is rather difficult since it combines certain good features with a number of less desirable ones. In the section on younger embryos, the drawings of reconstructions are excellent. However, inclusion of a series of cross-sections through different body regions for each representative stage would have made this part more useful as a guide in the study of serially-sectioned embryos. The duplicate English and German text is confusing especially since there are occasional errors in the translation from German into English. The drawings are labeled by means of guide lines and numbers, a single line sometimes going to two or more structures, thus making identification more difficult in these cases. A table beneath the text gives, for each number, the Latin name or else a German name or description followed by an English translation. In several instances, the English term given is not the same as the German.

Some errors were found in the labels for the drawings. It would be impossible to give a complete *erratum* here, but the following are a few representa-

tive examples. In figures 4 and 5, the blastocyst cavity is labeled "blastocoel," a term not well suited to mammalian development. The term "vacuolation space" is used indiscriminately for the beginning segmentation cavity in figure 4 and the blastocyst cavity and amniotic cavity in figure 7. In figure 37, a space between the ectoderm and mesoderm is labeled "umbilical vein"; in figure 43, aortic arch I is labeled "visceral arch I"; in figure 47, somatic mesoderm and splanchnic mesoderm are called "somatopleure" and "splanchnopleure" respectively; in figure 65, the term "ventricular mitoses" is applied to cell divisions not only within the brain, but also to those in the somite and mesonephros. The left colic flexure in figure 487 is labeled "flexura duodenojejunalis." A number of these errors appear to have occurred in translation since the German label is correct.

Perhaps the most confusing part of this book is the use of a very unusual and individual terminology which is based, in a large part, on the author's hypotheses concerning the mechanics of embryonic development. Many of these terms are explained in a glossary at the beginning of the book, but some are not. An example of the latter is the incorrect usage of the term "entoblast" for the amnion, amniotic cavity and bilaminar germ disc considered together and the term "ectoblast" for the trophoblast (figure 7). The term "entocyst" is used in older stages for the germ disc, amnion and definitive yolk sac. This is subdivided into "dorsal entocyst vesicle" for the amnion, "ventral entocyst vesicle" for the primary yolk sac and "entocyst disc" for the germ (figures 9, 13). Peculiar phrases which have meaning only in relation to the author's theories of developmental kinetics are "contusion fields" and "distusion fields" for growth areas of precartilage and cartilage, "dilation fields" for areas of muscle development, "encaptic subdivision" for subdividing units, and "parathelial deconsolidation fields" for areas of gland formation. It seems to this reviewer that the use of these abstruse terms in a book that is supposed to be an atlas and not a detailed account of theories concerning the mechanisms of development is both confusing and unnecessary.

Because of its many excellent illustrations, this book could be of considerable value to the advanced student of human embryology. It is not suitable for the beginning medical student or for a physician who wants a clear, concise account of human development.—Randall W. Reyer, Ph.D.

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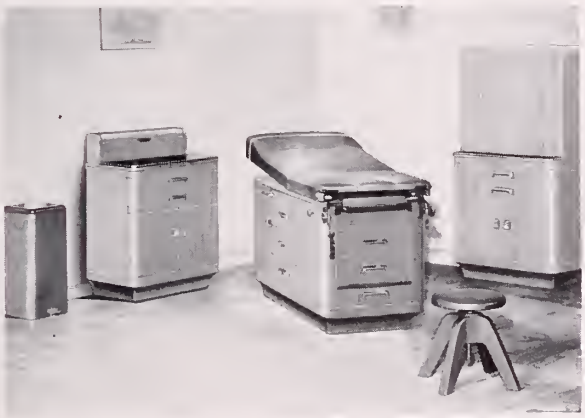

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Vol. 58 No. 3

The
WEST VIRGINIA
Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone Dickens 4-4625.

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The West Virginia Medical Journal

March, 1962 Vol. 58, No. 3

The Therapy of Pulmonary Emphysema*†

Charles E. Andrews, M. D.

Pulmonary emphysema is being recognized with progressive frequency in the clinical practice of medicine today. In the state of California, for example, a more acute awareness of the disease as a principal cause of death is evidenced by a 400 per cent increase in recording it as such on the death certificate.

Causes for the growing number of cases of pulmonary emphysema are not documented but factors such as the advancing age of our population, the increasing number of chronic smokers and the more widespread use of antibiotics, the latter of which perhaps has lowered the mortality rate of acute respiratory infections in emphysematous patients, all must be taken into account. In a recently reported series of cases in which the patients were followed to the time of death, emphysema was described as a disease characterized by cough and exertional dyspnea.[1] Most of these patients have "asthma," in attacks lasting several days and accompanied by dyspnea, cough, increased sputum production and, sometimes, fever. In the average case, characterized by Carroll's[1] series, the patient was in good health until the age of 49 years when symptoms of bronchitis and exertional dyspnea increased in severity. Cough and sputum generally were present and were continuous. At the age of 51 years exertional dyspnea was even more severe and by age 55 had forced the discontinuance of productive work. At age 58 there was right heart failure and weight loss; death occurred at the approximate age of 61 years.

Therapy, to be effective, should be directed toward correcting the abnormal anatomy and physiology produced by the disease. Figure 1 summarizes the abnormal physiology in relation to the important pathogenetic factors. Physiologic narrowing of the airways, with diminished ventilation, is the central physiologic defect. Decreased elasticity of the lung leads to narrowing of the airways. When elasticity is decreased, more work and greater pressure changes are required to move air. These factors lead to increase in the transpulmonary pressure so that it exceeds the intrabronchiolar pressure. When this occurs, the airways become narrowed because of the

The Author

- **Charles E. Andrews, M. D., Associate Professor of Medicine, West Virginia University School of Medicine, Morgantown, W. Va.**

CAUSES OF DIMINISHED VENTILATION IN PATIENTS WITH PULMONARY EMPHYSEMA

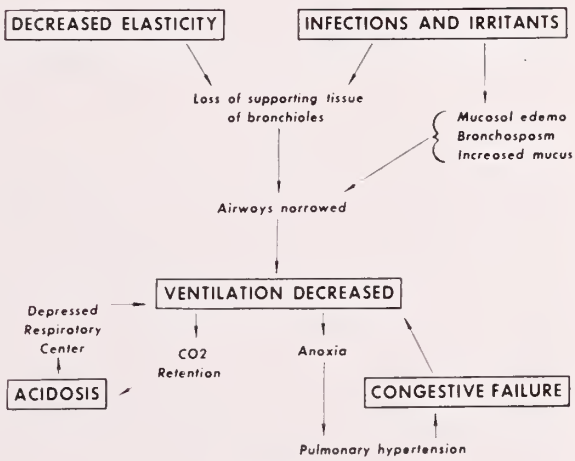

Figure 1

*Presented before the annual meeting of the West Virginia Chapter of the American Academy of General Practice in Charleston on May 19, 1961.

†From the Medical Service, West Virginia University School of Medicine, Morgantown, W. Va.

Submitted to the Publication Committee, September 29, 1961.

pressure differential. Infections and irritants lead to airway narrowing by producing bronchospasm or mucosal edema. As ventilation decreases, O_2 tension decreases. The resultant anoxia leads to increased pulmonary artery pressure which, plus loss of the pulmonary vascular bed, leads to hypertrophy of the right ventricle and congestive heart failure. The resultant failure leads to further decrease in ventilation and the cycle perpetuates itself.

Another result of diminished ventilation is CO_2 retention. The excessive carbon dioxide tends to depress the respiratory center so that the ventilatory drive is decreased. Thus, again we have a circus movement that leads to diminished ventilation. Treatment measures should be directed toward the four factors listed in the corners of Figure 1 since they appear to be of significance in the production of airway narrowing and diminished ventilation. We are concerned with correcting these factors from two points of view: (1) treatment of the acute exacerbation of dyspnea and (2) long-term maintenance of the patient in an attempt to prevent the acute exacerbation.

Infections and irritants may decrease the lumen of the airways by three mechanisms: (1) They can lead to the production of mucosal edema, a direct irritant effect. The capillaries are increased in number, with transudation of fluid into the interstitial tissue. (2) They may lead to bronchospasm, that is, contraction of the smooth muscle around the bronchiole. (3) Irritants stimulate bronchial mucous glands to produce an increased amount of secretion.

Several measures are of importance in prevention of the effects of infections and irritants. First and foremost is the attempt to get the patient to stop smoking. It has been shown many times that the heat and tars from cigarette smoke do lead to bronchial edema and increased mucus production.[2] Smoking meets a certain psychologic need in many instances but unless there are sound psychiatric reasons to the contrary, elimination of tobacco smoke should be the corner-stone of management in emphysema.

The second most important point in preventive maintenance in these cases is the routine use of bronchodilator drugs. In approximately 50 per cent of those cases in which the patient is in remission, a decrease in airway resistance will follow the use of nebulized isoproterenol. Its regular daily use is helpful even though the patient does not have an acute exacerbation of dyspnea. Used early in the morning, isoproterenol helps clear the tracheobronchial tree of mucus and other secretions that have accumulated during the night. If the patient is severely incapacitated, he should use a nebulizer prior to any heavy exertion or walking, much as the angina pectoris patient might use nitroglycerin before indulging in any activity that could produce an attack.

Influenza is a serious illness in emphysema patients, carrying high morbidity and mortality rates.[3] Yearly immunization with influenza vaccine is effective in preventing the disease. Current vaccines contain A, A^1, B and Asian strains of inactivated virus, and immunization with this material provides protection again these strains alone. Since the virus infecting a given population varies from year to year, the patient may not be protected in a given year but with annual vaccination some protection will be afforded most years since a particular strain tends to recur at regular intervals.

In the episode of acute dyspnea due to infection or irritant, proper treatment demands that the patient, if he be a smoker, completely abandon the habit and begin the routine use of bronchodilators, as previously mentioned, also that adequate hydration be maintained since a considerable quantity of water can be lost with rapid breathing rates, especially if fever is present. In dehydration, the mucus becomes thick, inspissated and difficult to eliminate, thus causing further narrowing of the airways. Nebulized water or saline will help saturate inspired air, with less net loss of water. Intravenous fluids often are indicated. Finally, antibiotics should be used. The usefulness of prophylactic antibiotics still is an open question, but certainly in the acute exacerbation of the disease antibiotics are indicated. It must be remembered that these patients may have serious infection without the development of fever or leukocytosis. A change in the sputum from white to yellow is indication enough to start antibiotic therapy. A broad spectrum antibiotic such as tetracycline is the drug of choice. If cultures indicate pneumococcus or streptococcus as the offending organism, penicillin should be substituted.

Several maneuvers are of help to the patient in lessening the effects of decreased elasticity of the pulmonary tissue. Breathing with the lips pursed often is helpful. He should learn to exhale as if about to whistle. Narrowing of the mouth tends to build up pressure in the airways so that they are less easily collapsed by the increase in transpulmonary pressure that occurs with expiration. Breathing exercises are highly recommended by some observers.[4] I have not obtained the excellent results from these procedures, however, that are reported by others. Such exercises are helpful in the sense that any improvement in muscle tone

or physical well being is helpful. In my experience breathing exercises have proved most effective in those cases in which the patient has been able to give up smoking. They provide him with something else to think about and to do. Finally, maintaining the patient in good general health so that he has good muscle tone is of benefit in that his muscles more efficiently perform the extra work required for breathing.

Decreased ventilation leads to anoxia. When anoxia is present for a prolonged period, with loss of the pulmonary vascular bed, pulmonary hypertension develops. This leads to congestive heart failure and further decrease in ventilation. Here, a digitalis preparation is indicated, as it is in any case of congestive failure. Diuretic therapy is extremely helpful and the chlorthiazide derivatives are the most useful diuretics. These drugs must be used with caution since they cause marked renal loss of potassium. With hypokalemia, digitalis intoxication is likely to occur. Supplemental potassium should be prescribed for any patient receiving diuretic therapy over a prolonged period. Finally, oxygen should be used. Remember that anoxia was a primary cause of the pulmonary hypertension. Frequently patients will respond more quickly to digitalis and other measures when the pulmonary artery pressure is lowered by O_2 administration.

Decreased ventilation also leads to carbon dioxide retention. This in turn leads to respiratory acidosis, with respiratory center depression and further decrease in ventilation. The marked dependence of carbon dioxide tension on ventilation is best illustrated in Figure 2. As alveolar ventilation decreases, alveolar CO_2 and blood pCO_2 increases and, conversely, as alveolar ventilation increases, alveolar pCO_2 decreases. Thus, some means of ventilation is absolutely necessary to excrete CO_2.

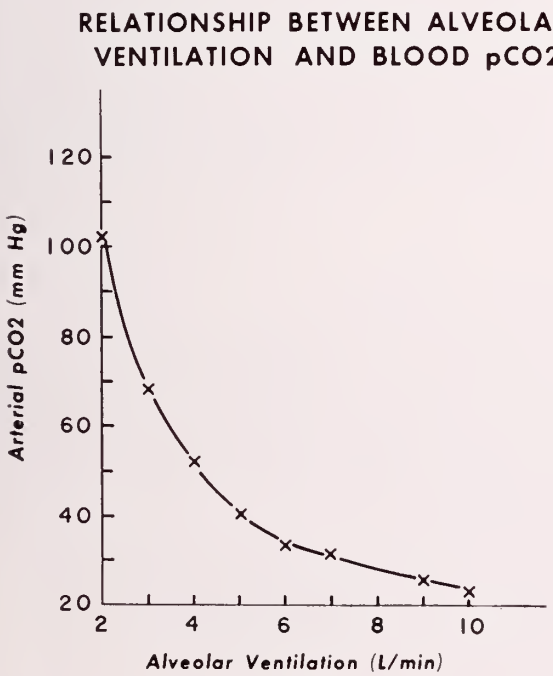

Figure 2

Mechanical ventilators offer one method of increasing ventilation and CO_2 excretion. The Drinker respirator effectively ventilates the patient with a negative pressure during inspiration, thus simulating the normal process. These respirators are bulky and inconvenient to use, however, and proper nursing care becomes difficult. Several types of intermittent positive pressure breathing devices that will effectively ventilate the apneic patient are now available. Models that allow regulation of air flow as well as pressure and have an automatic cycling device are most desirable.

Certain drugs are useful in temporarily decreasing the blood pCO_2 tension. Acetazolamide will temporarily lower the serum-carbon dioxide level, but I have not found it of particularly practical use in treating these patients. The respiratory stimulant, coramine (nikethamide NF), is helpful in temporarily increasing the ventilation of the patient with respiratory acidosis until antibiotics have time to control infection or digitalis has time to improve myocardial contractility. The drug is given by the intravenous route and the proper dose is the amount it takes to get an effect. This may vary from 2 to 5 ml. Coramine must be administered slowly since it may produce convulsions if given rapidly in large amounts. Coramine administration should be combined with mechanical ventilators and all other treatment measures that I have indicated. It must be remembered if ventilation is stimulated excessively the increased muscular activity will lead to increased production of CO_2. Thus the patient may produce more CO_2 by the increase in ventilation than he is able to excrete.

Oxygen therapy is necessary for the cyanotic, hypoventilating patient. The physician, however, must be aware of the hazards of O_2 therapy in the patient with respiratory acidosis.

Figure 3 illustrates the relation between ventilation, alveolar O_2 tension and hemoglobin saturation. Note that there is a point at which arterial O_2 saturation does not increase even though alveolar O_2 tension is increased by increasing ventilation. This is due to the O_2 carrying characteristics of hemoglobin and produces the sigmoid shaped curve when hemoglobin saturation is plotted against oxygen tension. The important implication from a therapeutic point of view is that by increasing the oxygen tension in inspired air by giving the patient 100 per cent O_2

you can saturate the hemoglobin regardless of what happens to the alveolar ventilation. In the case of the patient with severe pulmonary emphysema whose respiratory center is depressed by CO_2, hypoventilation develops. If he is breathing air, i. e., 20 per cent O_2, his hemoglobin becomes desaturated. Chemoreceptors in the carotid body are stimulated by decreased O_2 tension. When the hemoglobin saturation falls to around 85-90 per cent the carotid body then takes over as the primary source of respiratory drive. Ventilation increases until hemoglobin saturation reaches a level at which the carotid body is not stimulated. Apnea supervenes until desaturation again occurs. When the patient is given 100 per cent O_2 for his cyanosis, the alveolar O_2 tension increases. This leads to saturation of the hemoglobin (Figure 3) to a level at which it no longer stimulates the carotid body, and breathing ceases. More and more CO_2 accumulates and the patient becomes completely comatose, and may die. In such cases, the patient is in dire straits: If he does not get oxygen his brain cells will become anoxic and die. If he does get oxygen, in large amounts, he will become apneic and die from CO_2 intoxication. While it is necessary to give oxygen in such cases, the patient must be kept under continuous, close observation and the O_2 stopped at the first sign of apnea. When respiration is reestablished, the oxygen may be started again. By observing several such cycles, the length of time that O_2 can be administered safely can be established.

RELATIONSHIP BETWEEN ALVEOLAR VENTILATION BLOOD pO2 AND HEMOGLOBIN SATURATION

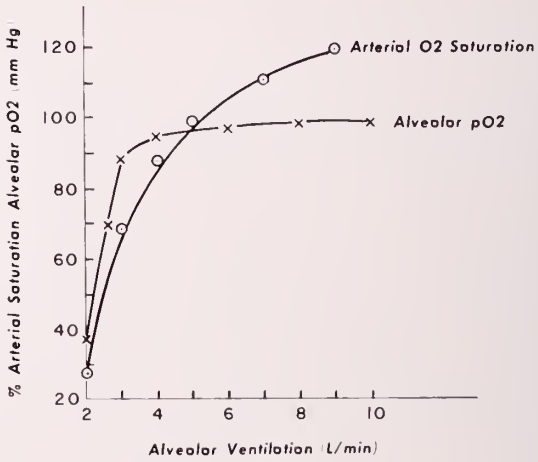

Figure 3

Summary

Management of the patient with pulmonary emphysema is directed toward prevention of the episode of acute dyspnea due to infection or congestive failure, with specific treatment for it when it does occur.

All emphysematous patients who smoke should completely abandon the habit. Bronchodilators should be used regularly.

Infections must be attacked vigorously, and maintenance of adequate hydration is called for during episodes of dyspnea. Mechanical aids to ventilation often are required to correct respiratory acidosis.

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The Challenge of Aging

Aging has been described as beginning at birth and continuing throughout life. It should be a process of continually maturing both physically and mentally. The challenge is to maintain high physical and mental capabilities by keeping active. This does not mean the development of muscles suitable for champion weight-lifting nor the intellectual activity that might be involved in solving the long-disputed method of light proplusion. It means, rather, a golden mean of physical exercise in moderation and the mental activity that might be conducive to understanding the quantum theory.

Metabolic change and exchange are the processes of growth and healthful living, therefore, we must undertake new ventures, learn new skills, and entertain new concepts and attitudes. A rigid pattern of life does not contribute much to development. When developmental changes cease to take place, senescence supervenes.—Charles Sellers, M. D., in Journal of the Michigan State Medical Society.

Useful Consciousness

Edward J. Van Liere, M. D.

THE words "conscious" and "unconscious" are used frequently in the medical literature. Many times the phrase, "Is the patient conscious?" may be heard in the hospital or on the telephone. It is possible, of course, for a patient to be semiconscious.

A number of years ago the term, "useful consciousness," appeared in the medical literature, especially in articles dealing with aviation medicine. Useful consciousness has been defined as that state in which the individual remains attentive and is able to perform useful or purposeful acts.[5] It has been defined also as a term expressing the length of time between oxygen deprivation and the onset of physical or mental deterioration.[3] The consensus is that the end-point of useful consciousness can be determined more accurately than that of total loss of consciousness. Obviously, it is difficult, if not impossible, to ascertain the exact time a subject becomes totally unconscious.

Gell[3] has emphasized that while the period of useful consciousness is determined primarily by altitude, it is influenced also by the inherent tolerance of the individual and is markedly affected by the amount of physical exercise.

Methods Used to Determine Interval Of Useful Consciousness

A common method to determine the end-point of useful consciousness is the handwriting test. Individuals wearing oxygen masks are placed in a low-pressure chamber. At a given simulated altitude, the masks are removed and the subjects start writing immediately and continue to do so for as long as possible.

Hemingway,[7] using this method, found that at a simulated altitude of 35,000 feet the period of useful consciousness averaged 72.6 seconds. The average oxygen saturation was 56.6 per cent. Ivy,[9] using a similar technique, observed that at 28,000 feet the period of useful consciousness was 3.0 minutes but at 36,000 feet it was only 1.2 minutes. He felt that the critical altitude was 26,000 feet in that none of the 49 subjects tested at this altitude was able to write longer than 15 minutes. He felt further that the ability to write persisted at arterial oxygen saturation greater than 66 per cent but that an arterial oxygen saturation of 75 per cent was the lower safe limit for voluntary direct movement. The latter figure corresponds approximately to 16,000 feet.

Submitted to the Publication Committee, December 8, 1961.

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Another simple method to determine useful consciousness is that of card sorting. The end-point is determined by noting the exact time of the appearance of any error. Hoffman et al.[8] found that the average period of useful consciousness at 28,000 feet and at 38,000 feet was 110 seconds and 35 seconds, respectively. They found an arterial oxygen saturation of 64 per cent at the appearance of the first error. They believed that at 56 per cent arterial oxygen saturation unconsciousness was imminent. They observed, furthermore, that the period of useful consciousness was approximately three-fourths of the time that total consciousness was retained.

Other methods of determining the period of useful consciousness, such as timing the subject's response to signals, have been described.

Effect of Acclimatization

It would be expected that acclimatization to altitude would prolong the period of useful consciousness; that this is true has been clearly shown experimentally. Individuals who sojourned on Mount Evans (altitude 14,160 feet) for a period of over six weeks, and who took considerable physical exercise, were able to extend the period of useful consciousness to 30 minutes at the great altitude of 30,000 feet.[1] This actually is a remarkable performance, because an unacclimatized person probably could live only two or three minutes at such an elevation. Parenthetically, it is of interest that Mount Everest, the highest mountain in the world, is 29,141 feet high.

In point of fact, a few weeks' sojourn at the modest altitude of between 6,000 and 10,000 feet may cause a significant lengthening of the period of useful consciousness at elevations as high as 26,000 feet.[2]

Other Means of Lengthening the Period Of Useful Consciousness

Although acclimatization to altitude offers the best method of prolonging the period of useful consciousness, there are several other means which may aid significantly. It was shown, for example, by Hall and his co-worker[6] that the addition of small amounts of carbon dioxide to ambient air at low barometric pressure increased the duration of useful consciousness. This effect, however, is more pronounced at lower than at higher simulated altitudes.

Riesen et al.[11] subjected 39 volunteers to a simulated altitude of 27,000 feet in a low-pressure chamber. Using the handwriting test as a criterion, it was observed that subjects lost useful consciousness, on an average, at the end of 187.5 seconds. Thirty-eight volunteers given a supplementary feeding of 80 Gm. of dextrose dissolved in 350 cc. of water two hours after a meal were subjected to the same procedure. The period of useful consciousness was found to be on an average of 261 seconds. This was a 40 per cent prolongation of useful consciousness as a result of glucose feeding. This figure was, of course, statistically highly significant.

The time of useful consciousness may be lengthened if the oxygen capacity is increased, for example, by a blood transfusion.

Oxygen Failure in Aircraft at High Altitudes

In the event of an emergency to the oxygen supply in an aircraft flying at extremely high altitudes, or in a space vehicle, every second of useful consciousness counts. A few additional seconds might enable members of the crew to make the necessary repairs.

As soon as there is a pronounced differential in atmospheric pressure between the air in the lungs and the ambient air, such as occurs at extremely high altitudes, the oxygen reverses its direction of flow. Instead of the oxygen in the lungs passing into the blood, the opposite obtains, namely, the oxygen in the blood goes back into the lungs. The process continues until equilibrium is reached with the oxygen in the atmosphere.

Gell[4] has pointed out that in the event of a foreseen oxygen failure the loss of oxygen from the blood and lungs can be delayed a minute or two if the following procedure is adopted: The subject should breathe pure oxygen and the lungs be over-ventilated for about one-half minute; just before the oxygen supply is cut off a deep breath should be taken and held as long as possible. Two things may be accomplished by this method: (1) The carbon dioxide is washed out of the lungs so that the normal stimulus to respiration is removed and (2) by holding the breath a high partial pressure of oxygen is maintained in the lungs and in the blood, since the oxygen is prevented from escaping into the ambient air. When the breath no longer can be held, oxygen should be inhaled at once, otherwise the subject will collapse quickly.

Explosive Decompression

Unfortunately, during explosive decompression such as might be produced by a fairly good-sized meteorite piercing a pressurized cabin, the interval of useful consciousness at extremely high altitudes, between 25,000 and 65,000 feet, is greatly diminished. Luft[10] has pointed out that at an altitude of 45,000 feet the interval would be approximately only 15 seconds. This obviously leaves little time to make any repair on the plane. If, however, the glottis is closed at the instant of explosive decompression, useful consciousness can be prolonged for as long as the breath can be held.

During explosive decompression the lungs often suffer irreparable injury because of the sudden differential of pressure between the air in the lungs and the ambient air. The circulatory system also may be gravely affected. The subject often goes into profound shock due to the reflex drop in blood pressure. These catastrophes can be prevented by wearing a partial-pressure suit and a proper helmet.

Useful Consciousness Following Coronary Occlusion

Although the interval of useful consciousness is primarily concerned with altitude, there are perhaps some clinical conditions in which prolongation of this interval may be important. For example, an individual driving a car might suffer a serious or even fatal coronary occlusion. A few additional seconds of useful consciousness might enable him to pull out of the line of traffic or turn off the ignition, or both. In doing so he may save not only the lives of his fellow passengers or individuals who might be in another car, but also the lives of possible pedestrians.

Summary

The period of useful consciousness may be defined as the time, following oxygen deprivation, in which an individual remains attentive and is able to perform useful or purposeful acts.

The time of useful consciousness can be measured more accurately than that of total loss of consciousness.

It is primarily determined by altitude, but it is influenced also by the inherent tolerance of the individual, and is markedly affected by the amount of physical activity.

The time varies as to altitude. Everything else being equal, the greater the altitude the shorter the time of useful consciousness.

In explosive decompression such as is produced when a meteorite pierces a space vehicle, the period of useful consciousness is approximately only 15 seconds.

Useful consciousness can be prolonged by acclimatizing to altitude, inhaling small quantities of carbon dioxide, ingesting glucose, and increasing the oxygen capacity of the blood by means of a blood transfusion.

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A Challenging Goal

The remarkable decrease in death from pneumonia and influenza is a most encouraging demonstration of progress. About 200,000 more people would have died last year had the death rate of the '30s for these diseases still prevailed. Better use of medical care by the public, however, and particularly the use of antibiotics discovered and made available in the 1940s have curbed much premature death. Still greater reduction in deaths from these diseases is possible. The devastating influenza epidemic of 1918-19 and the outbreaks in more recent years show us that prompt medical attention and better perceptions of illness can further improve mortality records.

But the reduction of premature deaths is only one principal objective of medical care. Another is the reduction of illness, and today this is undoubtedly the greater challenge. The amount of disability resulting from illness is still high—disability that may mean not only discomfort and expense for the individual and his family, but loss of working time and income. The extent of working days lost because of illness is staggering to the national economy.

In 12 months of 1958-59, according to the National Health Survey, respiratory conditions (the family of diseases that includes the common cold, influenza and pneumonia) were reported by the public to have caused over 700 million days of restricted activity —or nearly half the total of such days caused by all acute conditions. They accounted for an average of 4.1 "restricted" days per person in the country. Further, respiratory conditions were the cause of 53 per cent of all bed disability days, and 41 per cent of days of work lost.

The promise for the future is evident in these statistics. Research that may bring further control not only of influenza and pneumonia but of the common cold, deserves high priority in the health field. Reducing the shocking millions of days of restricted activity is but one small measure of the national gains that such research could bring. —George Bugbee, President, Health Information Foundation.

Special Article

Medical Education in Community Hospitals*

Barry Decker, M. D.

EACH of us must be well aware that the scarcity of interns and residents has crippled most community hospitals' programs of full-time in-hospital service. Each of us must be painfully aware of the inadequate number of clinically oriented practicing physicians facing a growing population ever demanding increasingly intensive medical care. We are only gradually becoming aware of the effect which changing attitudes towards medical education have upon these pressing problems and of the necessity for the entire profession, from "grass roots" to "high echelon conclaves," to concern itself with medical education.

Medicine a Service Institution

Several attitudes first require philosophic evaluation. Medicine often has been compared to a three-legged stool, with one leg each representing research, education and service, the three together comprising the integrated profession. To the lumpers this has been a point of pride and to the splitters a tipsy arrangement ill-favoring their own private area of concern. To me, the image is inappropriate indeed. It must be clearly borne in mind that from a national viewpoint, considering social and economic factors, medicine is a service institution. The cost of our expensive schools and hospitals, as well as professional income itself, is derived from the community in exchange for current or anticipated service. Research and education clearly are subordinate activities whose popular merit derives from the anticipation of better service at some future date. In this sense the community is investing in futures but the desired dividend of service remains unchanged.

Breaches of Allegiance

I have stressed the paramount importance of service in medicine because as a group we have lost sight of this goal, with defections taking the several forms of mammonism, exhaustion and narcissism. The first two have been faults of the practicing physician, the third, of academic medicine.

*Presented before the Sixth Annual Potomac-Shenandoah Valley Postgraduate Institute at Martinsburg, W. Va., October 27-29, 1961.
Submitted to the Publication Committee, November 10, 1961.

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No one denies that a hard working physician, after years of preparation and, often, deprivation, deserves a good financial return for his efforts. But the worship of mammon appears the moment the physician becomes more concerned with the fee involved than with the service rendered. Such a physician is the first to abuse the intern by utilizing intern service for personal gain.

Exhaustion occurs when a physician becomes responsible for more than he can satisfactorily perform and it results in a lower grade of service than is desirable. In all fairness, let it be said, however, that a physician so afflicted deserves sympathy, not censure, because peculiarities of geographic distribution and a general medical shortage have brought about the situation. An exhausted physician practicing marginal medicine, nevertheless, makes a poor intern preceptor.

Academic narcissism is a more subtle defection. Within the cloistered academic confines knowledge has traditionally been sought for its own sake. Medicine as an academic discipline has and should have a place within the universities. Unfortunately, from the viewpoint of medical service, large federal grants have converted a small disciplined academic plant into a major business operation which retains 55 per cent of available interns,[1] yet cares for only a small fraction of the nation's sick. These large federal grants have been given in the name of research and, while some good results have been achieved, the money has spawned a group of "academic operators."

We are all familiar with the venerated image of a dedicated former teacher who valued people and our education more than his own advancement. It is hard to find such a figure in today's academic environment, where faculties literally claw their way to national reputation by a major

interest in publication and only a minor or secondary interest in medical students. As Barzun[2] has said, "The name of research has changed from a simple description to a term of honor . . . and acquired an inherent sanctity; the quality of work and its results are secondary . . . to do research is deemed nobler than to teach; the men whose names bring prestige to a university are those whose research has impressed others of 'equal research potential.' For, I repeat, it is not deemed necessary to discover, if only one 'produces,' production being defined as 'publication.'" This type of academic medicine is divorced from a real sense of dedicated service to the community that supports it. The venerated object for such a faculty is, Narcissus-like, its own reflection. Furthermore, this "academic" environment, by virtue of its dominating influence on medical students, is in a position to attract these students to remain within the fold, resulting in perpetuation by constraining pupils in the image of teacher. There is a resultant net loss of clinically oriented house staffs in institutions caring for large segments of the public and ultimately a decreasing number of clinically oriented, service motivated physicians. These are the narcissistic aspects of current day academic medicine.

Internship and Residency

We must also define and examine our concept of intern and resident. The intern year is a period of apprenticeship during which the recent graduate experiences the use of his expensive medical education in controlled circumstances which permit him to make the necessary adjustments of putting theory into practice, and which gain for him the confidence he needs before he can continue on his own. As a medical student he acquired a basic understanding of the scientific disciplines inherent in medicine; as an intern he develops skill in the use of this knowledge. True, the intern continues to expand the base of his knowledge by reading, conference and lecture, but the heart of the internship is the bedside experience of meeting a medical problem head-on and discussing the collision with a battle-hardened veteran practitioner.

The resident, on the other hand, is a combination of advanced medical student and intern whose purpose is to deepen his factual and technical wisdom in a given area, while simultaneously gaining the practical skill and confidence of repeated experience. Straight internships have the same goals as first year residencies which, in effect, they are.

The Town-Gown Conflict

The third and last attitude for examination is the town-gown conflict. Those who have lived in many cities boasting medical schools have suffered first-hand, irresponsible condescension from the local school and have returned equally irresponsible hostility and mistrust. On a national level, the competition between affiliated and non-affiliated hospitals for house officers has been bitter. Many universities have discouraged senior students from taking internships in community hospitals by slurring comments about the quality of community hospital education and by the snide suggestion that the students would merely be abused. The community hospitals have returned this hostility in their way, by spiraling the wage and fringe remuneration for interns and by denying patient referrals to the local medical centers. The general community supporting, as it does, both the medical schools and the non-affiliated hospitals, suffers the net loss from such hostility. It hardly seems necessary to reiterate that the overall aim of medical service can best be served by a productive relationship between our medical schools and our community hospitals, with a trusting ". . . render unto Caesar . . ." attitude on both sides.

The Answer

Armed with these definitions, it now is possible to approach a solution to "Medical Education in Community Hospitals." In 1959-60 there were 7,081 American medical school graduates and an additional 1,753 qualified foreign graduates, making a total of 8,834 available interns. In 1959-60 there was a total of 7,770 nonaffiliated internships offered and 4,779 internships in university affiliated hospitals. During the same year there were 28,440 residents filling 87 per cent of 32,690 available residencies, with 54 per cent of these positions being offered in affiliated hospitals.[1] With a large resident staff as well as senior medical students to supply the specialty services of the affiliated hospitals, the entire output of American graduates could be utilized to fill almost completely the intern need of the non-affiliated hospitals. This suggestion neither is radical nor new. Several major teaching centers already have dispensed with internships, utilizing senior students and residents for the care of their patients and for their investigational need. What is new in this plan is the suggestion of its national application as well as the realization that it could be accomplished in one year by considered decision of the Council on Medical Education and Hospitals of the American Medical Association to discontinue the affiliated hospital rotating internship program. Would such an arrangement serve the best interest of all parties concerned? With certain protective modifications, discussed below, I believe it would.

University and Affiliated Hospital Organization

The universities and their affiliated hospitals are organized along strong divisional lines. Major departments in these institutions have more or less autonomous programs of continuing investigation and graduate teaching programs generally oriented towards one to four years of continuous training. Their major emphasis is the acquisition of scientifically detailed, investigational knowledge and the didactic instruction of medical students and residents. In general, such major university departments function best when staffed by residents and students. Rotating interns, during their brief two-to-four months tenure on service, often are difficult for these departments to assimilate and often wind up as "lost sheep."

The Nonaffiliated Hospital and the Rotating Internship

The nonaffiliated hospitals, on the other hand, are less strongly divided along divisional lines and by providing first line direct care for all patients within a given community, are best prepared to offer general experience to the graduate serving a rotating internship. Furthermore, the service needs of the nonaffiliated hospitals are practical and routine, and are best performed by interns, while the needs of the universities often are highly specialized, frequently investigational and usually best met by residents.

Provided that the educational values are maintained, the community hospital is in a better position to offer the most desirable features of a rotating internship. Redistribution of the approximately 6,000 American medical graduates desiring rotating internships, plus selected suitable foreign graduates, would more adequately meet the needs of the community hospital for full-time house staffs and would greatly increase their ability to perform service for the public at large. Meanwhile the affiliated hospitals would remain adequately staffed by residents and senior medical students.

Protective Modifications

There are, however, as previously implied, certain protective devices that must be considered in order to safeguard the educational value of the rotating internship. These same devices, incidentally, would improve the quality of private medical care in the community hospital.

The intern must not be regarded as cheap labor to enable the tired physician to attend his hospital patients more easily, nor as a tool for use by the avaricious physician in charging more people for in-hospital service he has not rendered. The purpose of an internship is controlled practice, which should be limited to between 20 and 25 patients.[3] The intern must have direct control of these beds (even though they be occupied by private patients), while the attending physician serves as consultant. The latter's obligation to his private patients will guarantee his daily consultation with the intern and his instructions regarding the proper care of each.

Those details of daily hospital service not pertinent to the intern's 20-25 beds should be managed by non-intern personnel. Ideally, all patients would be assigned to interns but in the face of house officer shortages, services in excess of those just stated must be assigned to others. Nurses can be trained to give intravenous medication, orderlies to perform catheterizations, laboratory technicians can learn all necessary intubation and aspiration procedures, while competent medical secretaries and transcribing equipment can simplify the problem of keeping hospital records.

Young physicians in the community can be hired for stated hours of in-hospital emergency coverage and, finally, practicing attending physicians can and must, when necessary, take and record their own histories and physical examinations or call in suitable attending consultation for the same purpose. The availability of interns in community hospitals under the auspices of a program such as is being suggested, should in no way constitute a license to delegate duties for which the attending physician is paid and is responsible, except as they enhance the intern's educational experience and training.

Each patient the intern studies must afford an educational opportunity. The intern must have sufficient time to interview and examine all of his patients, must have the opportunity to follow them throughout their hospital stay and, ideally, to see or at least learn of their post-hospital course. He must have bedside consultation with the patient's private physician and consultants (called by the private physician) or, when necessary, with ward rounding consultants appointed for the purpose by the hospital education committee.

The intern must be exposed to stimulating staff conferences which will convey to the impressionable young house officer his seniors' desire likewise to continue to learn. There should be regularly scheduled death and tissue reviews, so designed that intern and attending alike can review their errors and omissions in an atmosphere of constructive criticism without malice and without polite, rubber stamp restraint.

Rounds and conferences, however, must not be so frequent that they detract from the intern's patient contact which, after all, is his prime source of experience. At the Richmond Memorial

Hospital we have two one-hour didactic lectures weekly which are designed to review the application of basic science to clinical medicine. There is a one-hour clinicopathologic review of autopsies and surgical pathology, and there is a one-hour Journal Club; also, one hour is devoted to medical-surgical grand rounds. Formal ward rounds are scheduled three times weekly, with the remaining time devoted to patient care and to contact with private attending physicians.

Role of Neighboring Medical School

The neighboring medical school faculty can be of assistance to the community hospital by making ward rounds and participating in conferences, panels and lectures. The added aspect of graduate medical education plus the instruction and stimulation of practicing physicians should be consistent with the overall aims of the medical school. The various schools could broaden their regional hospital affiliations for this purpose. The addition of trained instruction in the community hospitals would greatly enhance the value of their teaching programs and simultaneously increase the local reputation of the medical school as well as offer the school the opportunity to maintain local standards of education and practice. Furthermore, the community hospitals already are investing heavily in house officer education and could easily afford to pay full-time medical school faculty honoraria comparable to those offered by the Veterans Administration. Such salary supplements paid for clinical instruction would hopefully attract more clinically oriented teachers to the faculties of our medical schools, where research now earns better dividends. Both the medical schools and the nonaffiliated hospitals would gain but the greatest overall boon would be the improved medical service to the community.

While trained, full-time medical school faculty might be employed to improve the education of the rotating intern in the nonaffiliated hospital, the intern still would be basically exposed to the main value of private practice, i. e., the greatest practical good for the patient. Unfortunately, academic narcissism has introduced the concept of the greatest good for the investigational project and disguised this essentially selfish end in the cloak of the greatest good for "humanity." I feel that "humanity" should be left to the philosophers. People are the proper concern of physicians and I would have all young physicians serve an apprenticeship in contact with people and the give-and-take of private practice. A period of instruction in a community hospital under good educational supervision, emphasizing the importance of practice would help to orient young physicians regarding the ultimate aim of medicine, namely, service to the patient.

The community hospital stands to gain enormously from such a program. With an adequate house staff, the hospital's service commitments can be met, permitting a higher quality of medical care. The nonaffiliated hospital, however, must not rely on interns alone for service; education must not be abused just because interns are in short supply. In satisfying service requirements otherwise, and in the proper management of intern education, the nonaffiliated hospital commits itself to considerable expense and increased effort on the part of its attending staff. The ultimate reward stems from the maintenance of a vibrant educational climate, so exciting as to "cause even the old men to stir." The individual gain for each staff member is great, not only in increased knowledge or as a means of keeping abreast, but in restoring the fun and anticipation that once were, and still can be, a part of medicine.

Program's Cost to Medical Schools

The cost of this program to the medical schools is small indeed. The schools must substitute senior students for rotating interns in the care of their own university hospital patients, a minimal risk when buffered by an adequate resident staff and a likely gain in undergraduate education. The schools must free a minute fraction of their faculty time but they gain supplemental income to attract additional faculty strength. The greatest gain, of course, lies in resumption, by the institutions of higher learning, of leadership in medical education by properly respecting their responsibility for medical service, both direct and indirect, to the communities to which they owe their support.

Summary

The proper concern of medicine, as it always has been and always will be, is service. To orient the on-coming physician in the field to this basic medical concept, his medical education should include a period of rotating internship in a nonaffiliated hospital.

If the Council on Medical Education and Hospitals of the American Medical Association were to decide to discontinue the university internship program, the output of American medical school graduates could easily complete the existing intern staffs of nonaffiliated hospitals, leaving an adequate number of senior students and residents to perform the specialized functions of the affiliated hospitals. The nonaffiliated or community hospitals so staffed must jealously guard the educational experience and training offered by the rotating internship by allocating all excess

duties to other personnel or to other paid professional help.

The universities should broaden their medical leadership by providing, as compensated consultants, faculty assistance in community hospital education programs.

In a cooperative atmosphere, and with a common goal, universities and nonaffiliated hospitals can enjoy happy, symbiotic relations.

Ultimately, improvement in patient care resulting from the internal efforts of the medical profession cannot help but restore medicine to its rightful position, which is that of leadership, that of a profession whose members are dedicated to service in the community.

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A Mutual Responsibility

When we speak of the relationship of physicians and dentists in the detection of cancer, we must more or less restrict our discussion to the detection of cancer of the face, neck and oral cavity. Since it is not usual for our professional associates in the field of dentistry to do complete physical examinations, we physicians do not expect them to find cancer of the breast, lungs, stomach or cervix. Yet, is this too much to ask? What about the complaints registered by so many patients visiting their dentists for emergency or routine dental examinations and treatment? How many times has the dentist heard the remark, "Doctor, I have a bad breath. I think my gums or teeth are causing it." Or again, "Don't you think my teeth might cause my stomach pains, since I can't chew my food properly?" Or, "I have pains in my back (or arms or hand). Do you think some infection in my gums is causing this?"

I feel quite certain that my dentist colleagues have heard all sorts of complaints blamed by patients on their teeth, gums, or anything else in the oral cavity. Some of these complaints might very well be the only clue and the cue that this patient must be seen by his family doctor for a complete checkup. Many patients will take care of their teeth, they are visible at all times, but will neglect the rest of their body. It is at the time when the dentist hears these complaints from his apparently healthy patient that he must suggest—no, insist—upon a complete physical examination by that patient's physician.

I firmly believe that if every dentist would take time during the first visit of a patient to listen for 15 or 20 minutes to his patient's complaints—not only those pertaining to the oral cavity, but general complaints—and allow the patient to talk about his entire physical being; and the dentist would insist that complaints other than those of he oral cavity must be investigated by a physician, I venture to guess that we physicians would detect more early cancers of the stomach, intestinal tract, lungs, breast, uterus, and other areas than we do now.—I. Phillips Frohman, M. D., in the Journal of the Kansas Medical Society.

'The Flabby American'

That well-known sobriquet, "The Ugly American," has been earned by those of our countrymen who have flaunted the supposed superiority of their homeland in the face of their hosts overseas. Of this we are ashamed. To our shame also it can be said that many of the same individuals, and unfortunately a multitude of others, have also earned the almost equally opprobrious title, "The Flabby American." How can a person who takes the elevator to go up two flights to his office, who gets out his automobile to travel three blocks, and who cannot even carry his own golf clubs pretend to be an example of vigorous health? Throughout history national over-prosperity has been the fore-runner of national downfall. Can Americans afford to lose the sturdy physical toughness that has allowed our forebears to build a nation such as ours.

What is the outlook today for the overfed, under-exercised "successful" men of the present day? He is well protected against infections generally as a result of public hygiene, modern antibiotics, and other measures, and his outlook for a longer life is definitely better than that of his father and grandfather. He does, however, have the constant threat of early atherosclerosis, particularly of his coronary arteries, with the chance of sudden death, even in his forties, hanging over his head like the sword of Damocles. He can look forward to the probability of spending his later years as a pulmonary cripple from the obstructive emphysema that has resulted from long years of inhaling cigarette smoke, provided of course that he had escaped the development of bronchogenic cancer.

We all know of the general tendency of the adult public to take its exercise vicariously by watching the exploits of professional athletes from an uncomfortable seat at the ball park or more often from the easy chair before the television. We all are familiar with the great yellow rather hideous school buses that deny our children the health-giving exercise of the daily walk to school, albeit we must admit that city streets are not the safest place for children to walk. This is but a minor instance of the great damage to the human race that has resulted from the development of the internal combustion engine. Perhaps human legs may, in the course of evolution, atrophy and disappear, they are so little used in the normal process of getting a person from place to place.

What of the cardiac patient, the man, for example, who has survived a myocardial infarction and finds himself relatively fit? In so many instances such a man, who may even be a doctor, is afraid to undertake the normal degree of exertion that is needed to keep his recently recovered myocardium in good condition. We find him avoiding stairs, always riding when he should walk in every way insuring that his heart muscle will stay in as poor condition as possible. Exercise, as Doctor Raab, Doctor Paul White, and others have clearly pointed out, is definitely beneficial to the damaged heart if kept within the bounds of its ability to respond and to increase its efficiency.

The situation is clear. Normal exercise, moderation in indulgence in three of the many curses of modern so-called civilization, rich food, cigarettes and cocktails, will do a great deal toward improving the health and the achievements of the people of this country and of making sure that in the future the average citizen is no longer "The Flabby American."—Rhode Island Medical Journal.

WALTER E. VEST, M. D.

1882-1962

In Memoriam

The West Virginia State Medical Association mourns the passing of Dr. Walter E. Vest, member, counsellor and friend.

Doctor Vest's whole life was dedicated to the service of mankind, and it can be said that inasmuch as life's success can be measured by achievement of purpose, he was eminently successful. He was interested in medicine as a science, as an art, as a scholarly pursuit, and as an opportunity to serve his fellow man.

Doctor Vest was imbued with a strong sense of responsibility of the physician to his profession and to his community. This conviction led him to accept tedious chores, committee assignments, and leadership in county, state and national organizations. If a society had a good purpose, its size or scope were unimportant. It would receive as careful attention as the business of his national affiliations. He brought to all these activities diligence of service, wisdom born of experience and study, tact and courtesy that is the mark of a true gentleman, and the faith of Christian principles.

Doctor Vest was Editor of our State Medical Journal for 25 years. His literary sensitivity elevated the scholastic quality of The Journal. Moreover, he believed The Journal should be an historical record of our Association for future members. This feature has made our State Journal unique and outstanding among medical publications.

Doctor Vest was Chairman of the Public Health Council and Medical Licensing Board for a score of years. Hundreds of physicians will recall that on receiving their West Virginia license, he gave this advice and admonition, "Be a good doctor, join your county medical society and be an active member, participate in the affairs of your church and your community." In the field of medical licensure his work was outstanding. He fathered the Medical Practice Act of West Virginia, which is generally rated as one of the best in this country.

Busy as he was in all these activities, his interest in clinical medicine never flagged. He continued to actively serve the sick; all other things came after this. At the onset of his first attack, he was making a night call on an old patient.

As a man of medicine, Doctor Vest's reputation was nationwide. Wherever you might go throughout this land, physicians learning you were from West Virginia would ask, "Do you know my friend, Doctor Vest?" To know Doctor Vest set the level for both friendship and medical negotiation. He knew people in every corner of the country, but if the physician were from the Old Dominion, he could spin his pedigree to the nth generation. Part of his distinction arose from his ability to lighten his talk, privately and publicly, with the apt story or anecdote. He had a classicists' interest in the Bible and Shakespeare and drew from these two sources to illustrate and adorn his speech and writing.

His was the greatest name in West Virginia Medicine in our generation. No one contributed more in a lifetime to the promotion of medical progress in the State of West Virginia than Doctor Vest. The memory of his wisdom, kindness and genial charm shall live on as an inspiration to all who knew him. Doctor Vest had those attributes which would have made him successful in any sphere of work he might have chosen, in any place he might have chosen. The West Virginia State Medical Association is most fortunate that he chose medicine as his career, and West Virginia as his home. So it is with gratitude that we give this last salute to a great man, a most beloved and revered friend.

George F. Evans, M. D.

The President's Page

United We Stand

It is not an uncommon human trait to believe the worst about any given situation when the facts are not known. Furthermore, it is well known that such beliefs are perpetuated, distorted and strengthened by constant repetition until they assume the semblance of fact. Thus a falsehood may be compounded until no amount of truth ever quite corrects the original assumption.

Such has been the widely circulated report of a financial crisis in the West Virginia Medical Assistance for the Aged program. The fact that the Commissioner of Welfare's financial report of January 11, 1962, did not substantiate his previous statements has not received wide publicity. It is not generally known that the MAA program in West Virginia will be operating until July 1, 1962, on funds appropriated by the Legislature to last only until December 31, 1961. It is indeed regrettable that the State of West Virginia, and the physicians practicing therein, should have been subjected to national ridicule as the result of this distortion of fact.

Some of you have expressed the opinion that we should have divorced ourselves from a program where the administrator had publicly expressed his opinion that he favored the Social Security approach for medical care of the aged. Certainly this would have been the easy way out but I am sure that by so doing we would only have supplied ammunition to those who would see all health care administered by Federal decree.

Sometimes in the heat of battle we lose sight of our original concept, viz.; to supply medical care for a segment of our older citizens who need assistance. With this in mind, what has been accomplished by our continuing to participate in the MAA program? First of all, our state legislators have seen fit to continue financial support of the MAA program. Unfortunately their decision to appropriate only the sum of $1,300,000, which is approximately half the amount provided previously, will make it difficult to provide a completely comprehensive program. I am sure the members of the Legislature were influenced by the unnecessary and unfavorable publicity which the program had received and the reduction of funds was their reaction. We should make every effort to cooperate to the best of our ability to provide as extensive medical care as possible within the funds available. Perhaps if good use is made of existing funds the Legislature may see fit to increase the amount in the future.

The fact that eligibility has been made more realistic, so that those now receiving care represent people who need assistance, should eliminate any objections that previously existed under the original regulations. Now, for the first time, we have an opportunity to really participate in the formulation of policies designed to constantly improve the implementation of the MAA program. This will be the function of the Joint Conference Committee meeting at regular intervals with the Commissioner of Welfare.

Our offer to police our own ranks by the formation of District Review Committees has been accepted. These committees should eliminate any questions of overutilization due to ignorance of the provisions of the program or greed. Certain of our members have been unjustly accused in this regard and this must be corrected. The fact also remains that there are a few in every profession whose action cannot be defended. This we must realize and guard against.

To those of us who have been in the thick of the recent engagement, it seemed like a long war but we can really think of this as only a skirmish—the main fight lies ahead. I hope you do not become discouraged or pale at the thought of the hard work that must be forthcoming if the best medical care in the world is to survive. All of us must realize we cannot in our lifetime ever return to those days in our past when we could exclusively confine our talents to the care of the sick and injured. In these days of the New Frontier there is a decadent philosophy of Federal paternalism which is invading the very core of our nation. We must fight this on whatever front it appears, whether or not it involves us personally.

D. E. Greeneltch, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.

EDITORIALS

WALTER E. VEST, M. D.

Dr. Walter E. Vest, 80, of Huntington, Editor of *The Journal* for more than a quarter of a century, died at a hospital in that city on January 28. Although he had been in ill health for several years, his death came unexpectedly and was attributed to hypertensive cardiovascular disease with terminal left ventricular failure.

Doctor Vest was born at Terry's Fork, Floyd County, Virginia, on January 20, 1882, a son of the late William Madison and Mary Susan Boone Vest. He was graduated from the College of William and Mary in 1902, and received his M. D. degree from the Medical College of Virginia in 1909. He served his internship at Memorial Hospital in Richmond, 1909-10, and located for practice in Meherrin, Virginia.

He was licensed to practice medicine in West Virginia in 1916 and moved to Huntington, where he engaged in the practice of his specialty of internal medicine until his death.

During World War I, he served as chief of medical service at the base hospital at Camp Wadsworth, South Carolina.

Doctor Vest served a term as president of the Cabell County Medical Society and was a member of the Council of the West Virginia State Medical Association. He was named president of the Association in 1930. He served as an alternate delegate to the American Medical Association, 1930-34, and served as delegate to the AMA from 1934-58. He served on several key committees and councils of the AMA and was a member of the Council on Constitution and Bylaws at the time of his death.

He was named a member of the Publication Committee of the West Virginia State Medical Association in 1923 and, in 1937, was named Chairman and Editor of *The West Virginia Medical Journal.*

He was also active in the Southern Medical Association and was named president of the organization in 1938. He served as president of the Federation of Licensing Boards of the United States, 1952-53.

He was a member of the West Virginia Public Health Council, 1933-49, and chairman, 1937-49. When the Medical Licensing Board was organized in 1949, he served as its chairman until 1952.

He was a past president of the West Virginia Hospital Association, Association of Surgeons of the Chesapeake and Ohio Railway, American Therapeutic Society, American Geriatrics Society, Alumni Association of the College of William and Mary, the Alumni Association of the Medical College of Virginia, the West Virginia Tuberculosis and Health Association, Section on Chest Diseases of the American Medical Associa-

tion, and a past Governor of the State Chapters of the American College of Physicians and the American College of Chest Physicians.

Doctor Vest held an honorary Doctor of Science degree conferred on him by the Medical College of Virginia and an honorary Master of Arts from the College of William and Mary.

He was a member of Phi Beta Kappa and was certified by the American Board of Internal Medicine. He was a Fellow of the American College of Physicians and the American College of Chest Physicians.

His wife, Mrs. Saddie Blankenship Vest, died in July, 1961. Surviving are a son, Dr. Walter E. Vest, Jr., of Denver, Colorado; a brother, Robert Vest of Roanoke; and two grandchildren.

A LONG CAREER OF OUTSTANDING SERVICE

The death of Dr. Walter E. Vest, on January 28, 1962, brought to an end a long career of most outstanding service. A true gentleman of the old school, Doctor Vest was first and foremost a humanitarian physician, whose concern for the real welfare of patients outweighed all other considerations.

This same spirit of dedication to the principle of the pursuit of excellence was invariably evident in the many areas of work in which he served the physicians and the people of West Virginia.

As a representative of physicians in State and National medical organizations, his firm insistence on highest standards earned the respect and support of all. As member and chairman of the Medical Licensing Board of the State of West Virginia, his diligence and ability brought national recognition. As long-time Editor of *The West Virginia Medical Journal*, his guiding hand was continually evident in the selection for publication of material of timely interest and importance.

Doctor Vest demonstrated daily in his own way of life his firm conviction that the education of the physician is a never-ending process. For many years a member of the Visiting Committee of the West Virginia University School of Medicine, he was thoroughly conversant with the operation of the School, and one of its staunch supporters. All who were privileged to know him will continually be influenced by his example.

E. J. Van Liere, M. D.
Clark K. Sleeth, M. D.

PHYSICIAN, CITIZEN AND FRIEND

Divine services for Dr. Walter E. Vest in Huntington today will bring mourners from every section of West Virginia. Thousands of others will be here in spirit to pay their respects to a great physician and an even greater citizen. In an age of specialized medicine, when the tendency of the profession is to compartmentalize not only professional skills but extra-professional duties, Doctor Vest was an admirable exception. He gave as unstintedly of himself in public service as he did in private practice.

For 25 years Doctor Vest was editor of *The West Virginia Medical Journal*. During that period he often made the publication useful to non-medical readership, while at the same time drawing the attention of other busy doctors to State and national problems for which he felt they should take joint responsibility with lay citizens.

Much could be said in praise of the quality and length of service which Doctor Vest gave to community and State undertakings. He was so prodigal of his great energy that few matters of civic importance failed to find him in the forefront of those striving to inform and persuade an often apathetic citizenry.

But encomiums for his work were never worn by Walter Vest as medals. At an age when most men are willing to look backward at past achievements, he was forever looking forward to new things with an enthusiasm that never flagged.

As physician and civic-minded citizen, Walter Vest will be sorely missed. But his legion of friends will feel the greatest sense of loss at his passing.—*The Huntington Herald Dispatch.*

USEFUL CONSCIOUSNESS

Elsewhere in this issue may be found an article dealing with the time of useful consciousness. Although the interval of useful consciousness relates primarily to oxygen lack, it is also influenced by the inherent tolerance of the individual and is markedly affected by physical effort.

Everything else being equal the higher the altitude, that is, the lower the oxygen tension, the shorter the period of useful consciousness. Gell[1] found that at 40,000 feet useful consciousness lasts 30 seconds; at 35,000 feet from 45-60 seconds; at 30,000 feet from 20-90 seconds, and at 25,000 feet from 2-3 minutes. The time of useful consciousness can be reliably determined by

using simple tests, such as handwriting or response to signals, during the period the subject is deprived of oxygen. Obviously, it is practically impossible to establish the exact time of total unconsciousness.

The time of useful consciousness might appear to be of purely academic interest, but this is not true. A few additional seconds of useful consciousness can be life-saving. For example, repair work to be made on aircraft flying at high altitude or on a space vehicle could well depend upon whether the mechanic would remain conscious long enough to do the job.

Unfortunately, during explosive decompression, such as might be produced by a meteorite piercing a space vehicle, the time of useful consciousness is only about 15 seconds, due to the tremendous difference between the pressure in the lungs and that of the ambient air. This interval may be somewhat prolonged by holding the breath as long as possible. The danger to the lungs and the circulatory system during explosive decompression can be largely prevented if the subject wears a partial-pressure suit and a suitable helmet.

As the article points out in certain clinical conditions the interval of useful consciousness may be extremely important. A motorist stricken with a fatal coronary occlusion, theoretically has about 15 seconds of useful consciousness. During this period he could pull out of the line of traffic, shut off the car's ignition and set the hand brake. By so doing he may save the lives of his passengers and of possible pedestrians. Indeed, there have been instances that the stricken motorist has done this very thing just before he died. One difficulty, is often that a coronary insult is associated with excruciating pain. This, of course, may prevent the subject from carrying out any useful or purposeful act.

1. Gell, C. F., Aerospace Medicine (Baltimore: Williams & Wilkins Co., 1961).

Our Responsibility

It is our responsibility as physicians to aid in educating our patients in the value of periodic examination, not only in the detection of early malignancy but also in the detection of diseases of other areas of the body such as the cardiovascular system. It is also our responsibility to provide our patients with periodic physical examination and to guide them in the need for specific laboratory and/or radiographic studies.

Tremendous strides are being made in the development of aids in the early diagnosis of malignancy, but the keystone of diagnosis is still a careful history and complete physical examination done by an interested, thoughtful physician.—George A. Hahn, M. D. in The Pennsylvania Medical Journal.

Colossal Waste

Medical schools, like most others, do not traditionally teach year around. From the time a student starts as a freshman until he has his license to practice, he has studied for about 34 months over a period of about four years. The difference, equal to more than one whole year, is the greatest waste of time in a most valuable period of a professional man's life.

The reasons for and against an around-the-year schedule in undergraduate schools have been thrashed out many times. The reasons are not basically different as applied to medical schools. Measuring efficiency in dollars, it is plain that industry could not operate profitably by working 8 months out of the year. Also, it has never been proved that teachers need 2 to 4 months rest each year any more than do some high pressure executives or clerks. With air-conditioning, intense mental effort need not be any more exhausting in the summer than at any other time of the year. The most cogent reason for shutting up shop for the summer is the student's need to earn money to assist him for the next academic year. All other reasons make summer vacations desirable but a luxury he can ill afford.

The need for periodic relief from grueling intellectual endeavor is better served by shorter and more frequent interruptions. One week of freedom in every quarter-year would be adequate. It would not be traditional, but it would still give medical students more vacation than some demanding careers allow, including their own. Teachers would be expected to work a year for a year's pay and to make use of the sabbatical year. The periodic breaks in the use of facilities allow time to paint and repair. The important result of such a schedule is that 4 years of time can be telescoped into three. To study 11 months a year for 3 years approximate the 34 months now required.—Massachusetts Physician.

A Serious Obligation

It seems reasonable to suppose that any person who is ill for any reason whatever, and who seeks medical advice, is most likely to be concerned with several questions which may be generalized as follows:

(1) What has happened to me? (2) What is its meaning? (3) What should be done about it, and (4) How am I to get along?

It is suggested that these questions should be answered, insofar as it is reasonably possible, and a clear picture should be presented at least to a responsible member of the family, and probably to the patient. A very solemn and serious obligation is imposed by these questions.

In brief, of course we should apply the old adage of trying to treat our patients as we ourselves would like to be treated. Any service which omits this principle is inadequate and unworthy.—Clinton Gallaher, M.D., in Journal of the Oklahoma State Medical Association.

Cease to inquire what the future has in store, and take as a gift whatever the day brings forth.—Horace.

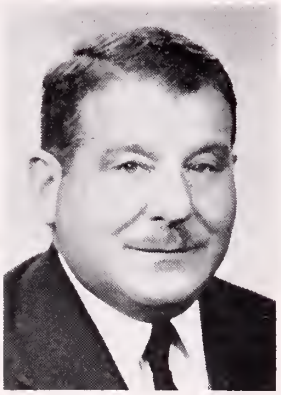
GENERAL NEWS

Drs. Ravdin and Wright To Speak At 95th Annual Meeting

Drs. I. S. Ravdin of Philadelphia and Irving S. Wright of New York City have accepted invitations to appear as guest speakers at the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25.

Doctor Ravdin, who is Professor of Surgery and Vice President for Medical Affairs at the University of Pennsylvania, will appear as a speaker at the first general scientific session on Thursday morning, August 23.

A native of Evansville, Indiana, Doctor Ravdin received his M. D. degree in 1918 from the University of Pennsylvania School of Medicine and served an internship and residency at the University of Pennsylvania Hospital.



I. S. Ravdin, M. D.

Irving S. Wright, M. D.

Doctor Ravdin is immediate past president of the American College of Surgeons and he served for six years as a member and chairman of the Board of Regents of that organization. He also is a past president of the American Surgical Association and the International Society of Blood Transfusion.

He is now serving as vice president of the American Cancer Society and will be installed as president elect in October.

Doctor Ravdin is Chairman of the Clinical Studies Panel, Cancer Chemotherapy National Service Center, National Institutes of Health, and a member of the National Advisory Health Council. He also serves as Senior Civilian Consultant to the Surgeon General of the United States Army.

He appeared as a speaker at the 88th Annual Meeting at The Greenbrier in 1955.

Irving S. Wright, M. D.

Dr. Irving S. Wright, who is Professor of Clinical Medicine at Cornell University Medical College, and Attending Physician at the New York Hospital, will present a paper at the second general session on Friday morning, August 24.

A native of New York City, Doctor Wright was graduated from Cornell University and received his M. D. degree from Cornell University Medical College in 1926.

He served as Professor of Clinical Medicine and Director of the Department of Medicine at New York Postgraduate Hospital and the Columbia University College of Physicians and Surgeons, 1938-46.

During World War II, Doctor Wright served as Consultant in Medicine to the Surgeon General of the United States Army and Air Surgeon with the rank of Colonel. He also was Chief Coordinator of a Survey of the Health of Repatriated American Prisoners of War of the Japanese. He served from 1946 to 1948 as a member of the Civilian Advisory Committee to the Secretary of the Navy.

Doctor Wright is a past president of the American Heart Association and was the recipient of the Albert Lasker Award in 1960. He served as chairman of the Section on Experimental Medicine and Therapeutics of the American Medical Association, 1938-39.

He is certified by the American Board of Internal Medicine and is a Regent of the American College of Physicians. He has been a member of the editorial board of the American Heart Association since 1950, and also served as a member of the board of *Annals of Internal Medicine*, 1957-59.

Doctor Wright was among the pioneers in the modern study and treatment of peripheral vascular diseases, and he organized and served as chairman of the first and second National Conferences on Cerebral Vascular Disease, 1954-57.

Scientific Program Nearly Completed

Dr. Halvard Wanger, chairman of the Program Committee, said that arrangements have nearly been completed for the general scientific program which will be presented during the three-day meeting. The other members of the committee are Drs. George P. Heffner of Charleston and Charles D. Hershey of Wheeling.

The names of the other prominent physicians and surgeons who will appear as guest speakers will appear in future issues of *The Journal*.

AMA President to Speak

The Program Committee announced previously that Dr. George M. Fister of Ogden, Utah, who will be installed as president of the American Medical Association at the annual meeting of that organization in June, will attend the meeting and speak before the final session of the House of Delegates on Saturday afternoon, August 25.

Dr. D. E. Greeneltch of Wheeling, president of the State Medical Association, will present his presidential address before the first session of the House of Delegates on Wednesday evening, August 22.

State Physicians To Present Papers At ACOG Meeting in Chicago

Several West Virginia physicians will present papers at the 10th annual clinical meeting of the American College of Obstetricians and Gynecologists which will be held at the Palmer House in Chicago, April 1-4.

Drs. Herman W. Rannels of Man and Gates J. Wayburn of Huntington will present papers at breakfast conferences on Tuesday, April 3. Doctor Rannels will discuss "Problems of Rural Obstetric Practice," and the subject of Doctor Wayburn's paper will be "Uterine Inertia."

Dr. John T. Chambers of Charleston will present a paper at a breakfast conference on Wednesday. His subject will be "Breech Presentation in the Primipara."

More than 2,000 physicians are expected to attend the four-day meeting. Dr. Edward C. Hughes of Syracuse, New York, will be installed as president of the organization on Tuesday, April 3, and he will deliver his inaugural address at that time.

Dr. Luther L. Terry, Surgeon General of the United States Public Health Service, will be the principal speaker at the banquet which will be held on Monday evening.

'Medicine in Sports' Newsletter

"Medicine in Sports," a newsletter devoted exclusively to reporting the latest information on the care and prevention of athletic injuries, is now being distributed to all interested physicians by the Rystan Company of Mt. Vernon, New York.

The newsletter regularly provides summaries of medicine in sports, coverage of meetings and symposia on a nationwide basis, and articles by authorities in the field.

Physicians interested in receiving the publication are requested to contact Charles Stanton, Editor, the Rystan Company, 7 N. MacQuesten Parkway, Mt. Vernon, New York.

Ob. & Gyn. Examinations

The American Board of Obstetrics and Gynecology has announced that the next scheduled examinations (Part II), oral and clinical, will be held at the Edgewater Beach Hotel in Chicago, April 9-14. The deadline date for the 1963 examinations is July 1, 1962.

Further information may be obtained by writing the secretary, Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6, Ohio.

WVU Medical Center Joins Cancer Chemotherapy Study Group

The West Virginia University Medical Center was accepted on February 14, 1962, as a member of one of the Cooperation Study Groups for Cancer Chemotherapy under the sponsorship of the National Institutes of Health. This study group is composed of twelve institutions including the National Cancer Institute, Mayo Clinic and Roswell Park Memorial Institute.

The purpose of the study groups is to evaluate drug therapy in the control of cancer in human beings as new anti-cancer drugs are developed in the laboratory. Such drugs are used in conjunction with or to supplement surgery, x-ray therapy and established beneficial drug regimens.

The West Virginia University Medical Center is particularly anxious to evaluate cancer chemotherapeutic drugs in adults and children with leukemia, Hodgkin's disease and other lymphomas, multiple myeloma and all the solid tumors of children. These types of malignancies in the past have been shown to be most responsive to chemotherapy and provide the means of evaluating the best response to this form of therapy at the present time.

Dr. Barbara Jones, Assistant Professor of Pediatrics, is in charge of the program concerning children and Dr. John B. Harley, Assistant Professor of Medicine, is in charge of the adult program. Dr. William G. Klingberg, Professor of Pediatrics, is the coordinator of the program for West Virginia University Medical Center.

American Soc. of Internal Medicine To Meet in Philadelphia

The sixth annual meeting of the American Society of Internal Medicine will be held at the Benjamin Franklin Hotel in Philadelphia, April 6-8. Business meetings will be held on Friday, April 6, and the scientific sessions on Saturday and Sunday.

The themes of the two general scientific sessions will be "Development of Quality in the Practice of Internal Medicine," and "The Control of Quality in the Practice of Internal Medicine." The presiding officers will be Drs. Sidney O. Krassnoff and Robert T. Porter.

Walter J. McNerny of Chicago, president of the Blue Cross Association, and Wilbur J. Cohen, Assistant Secretary, Department of Health, Education and Welfare, will be among the speakers.

Additional information concerning the program may be obtained by writing the American Society of Internal Medicine, 3410 Geary Boulevard, San Francisco 18, California.

Relocations

Dr. John D. German resigned as Chief of Surgery and Senior Surgeon at the Miners Memorial Hospital in Man, West Virginia, effective February 1. His temporary address in Man is 100 West Fifth Street.

New Association Members

Dr. Charles E. Andrews, WVU Medical Center, Morgantown (Monongalia). Doctor Andrews, a native of Stratford, Oklahoma, was graduated from New York University and received his M. D. degree from the Boston University School of Medicine in 1949. He interned at the University of Kansas Medical Center, 1949-50, and served a residency there and at the Wichita VA Hospital. He also served a fellowship in pulmonary diseases at the Minnesota VA Hospital and the University of Minnesota. He served in the United States Army during World War II and as a Captain in the Medical Corps of the United States Air Force, 1951-53. His specialty is internal medicine.

* * * *

Dr. Rex B. Conn, Jr., WVU Medical Center, Morgantown (Monongalia). Doctor Conn was born in Marengo, Iowa, and received his M. D. degree from the Yale University School of Medicine in 1953. He interned at University of Minnesota Hospital, 1955-57, and served a residency there, 1957-60. He took postgraduate work in biochemistry at the University of Oxford, and in hematology at the University of Minnesota. His specialty is clinical pathology.

* * * *

Dr. Edmund B. Flink, WVU Medical Center, Morgantown (Monongalia). Dr. Flink, a native of Isanti, Minnesota, received his M. D. degree from the University of Minnesota Medical School in 1938. He received his Ph.D. degree in 1945. He interned and served a residency in internal medicine at the University of Minnesota Hospital. He previously served as professor in the Department of Medicine at the University of Minnesota Medical School.

* * * *

Dr. Barbara Jones, WVU Medical Center, Morgantown (Monongalia). Doctor Jones was born in Salt Lake City, Utah, and was graduated from Stanford University. She received her M. D. degree from the University of Utah School of Medicine in 1952 and served an internship and residency in pediatrics at the St. Louis Children's Hospital, 1952-55. She previously served as a member of the faculty of the Department of Pediatrics at Washington University School of Medicine in St. Louis.

* * * *

Dr. William G. Klingberg, WVU Medical Center, Morgantown (Monongalia). Doctor Klingberg, a native of Wichita, Kansas, was graduated from the University of Wichita and received his M. D. degree from the Washington University School of Medicine in St. Louis in 1942. He interned and served a residency in pediatrics at the St. Louis Children's Hospital. He served with the Medical Corps of the United States Army, 1945-47, and previously was a member of the faculty at the Washington University School of Medicine.

Medical Library Assn. Meeting

The 61st Annual Meeting of the Medical Library Association will be held at the Sheraton-Chicago Hotel in Chicago, June 4-8. The convention chairman is Donald Washburn, D.D.S., 222 E. Superior Street, Chicago, Ill.

Refresher Course in Anesthesiology In Morgantown, April 28-29

Dr. R. G. B. Gilbert of Montreal, Canada, will be the guest speaker at a Refresher Course in Anesthesiology which will be conducted at the West Virginia University Medical Center in Morgantown, April 28-29. The course, which will be presented by members of the Department of Anesthesiology, will be held in conjunction with the Spring Meeting of the West Virginia Society of Anesthesiologists.

Doctor Gilbert, who is Professor and Chairman of the Department of Anesthesiology at McGill University and Chief of Anesthesia at Montreal Neurological Institute, will present two papers during the meeting. Several members of the School of Medicine faculty will participate and present papers.

Dr. Harry S. Weeks, Jr., of Wheeling, president of the Society, will preside and also take part in a seminar on obstetrical anesthesia. An address of welcome will be delivered by Dr. Kenneth E. Penrod, Vice President, WVU Medical Center. The complete program follows:

Saturday, April 28

"Principles Governing the Uptake of Anesthetic Gases by the Body."—Allen E. Yeakel, M. D., Assistant Professor of Surgery (Anesthesiology), WVU School of Medicine.

"Factors Affecting Cardiac Output."—R. J. Marshall, M. D., Associate Professor of Medicine and Chief of the Department of Cardiology. WVU School of Medicine.

"Reticular Activating System."—Robert J. Johnson, M. D., Professor and Chairman of the Department of Gross and Neurological Anatomy, WVU School of Medicine.

"Transfusion Reactions and Their Management."—Rex B. Conn, M. D., Assistant Professor of Medicine and Director of Clinical Laboratories, WVU School of Medicine.

"Anesthetic Management of Severe Injuries."—R. G. B. Gilbert, M. D.

"Causes and Physiological Effects of Hypercarbia."—Allen E. Yeakel, M. D.

"Hyperventilation."—N. W. B. Craythorne, M. D., Associate Professor and Acting Chairman of the Division of Anesthesiology, WVU School of Medicine.

Sunday, April 29

Equipment in the Department of Anesthesiology will be displayed Sunday morning, beginning at 8 o'clock, and a one-hour seminar on Obstetrical Anesthesia will be presented at 9 o'clock. The participants will include Drs. Weeks, Craythorne, Yeakel and N. W. Fugo, Professor and Chairman of the Department of Obstetrics and Gynecology. The remainder of the program on Sunday will be as follows:

"Prolonged Apnea."—N. W. B. Craythorne, M. D.

"Auxiliary Block."—Allen E. Yeakel, M. D.

"Anesthesia for Thoracic Surgery."—R. G. B. Gilbert, M. D.

"Hazards of Postoperative Period."—N. W. B. Craythorne, M. D.

"Respiratory and Cardiac Resuscitation."—Allen E. Yeakel, M. D.

Doctor Weeks announced that all interested physicians are cordially invited to attend the meeting.

Venereal Disease Literature Available to Physicians

The United States Public Health Service has announced that a publication entitled "Current Literature on Venereal Disease" is available free of charge to physicians.

Since 1957, infectious syphilis has been increasing at an alarming rate in all races, sexes, ages, social groups and geographic areas. Physicians who have not observed a single case of infectious syphilis in 20 years suddenly are finding it among their patients. Concurrent with this resurgence, unfortunately, is a paucity of venereal disease literature and information available to the private physician.

To partially alleviate this situation and serve a pressing need, the Venereal Disease Program of the Public Health Service routinely abstracts current articles on venereal diseases from almost 1,000 journals both domestic and foreign. This material is included in the publication described above.

Physicians interested in having their names added to the mailing list to receive the publication may write to Dr. William J. Brown, Chief, Venereal Disease Branch, Communicable Disease Center, Atlanta 22, Georgia.

Cancer Workshop in Washington

A Cancer Workshop, sponsored by the American College of Surgeons, will be held at the Sibley Memorial Hospital in Washington, D. C., on April 18. The program for the one-day meeting will deal primarily with cancer registries and their value to research, the hospital and community. The financial report of registries also will be discussed.

Additional information may be obtained by writing Dr. John Orem, Sibley Memorial Hospital, 52255 Loughboro Road and MacArthur Boulevard, Washington, D. C.

Symposium on Clinical Allergy

A Symposium on Clinical Allergy will be held at the Mound Park Hospital in St. Petersburg, Florida, April 19-21. The registration fee is $40. Additional information may be obtained by writing Dr. M. A. Barton, Mound Park Hospital Foundation, 701 Sixth Street, South, St. Petersburg, Florida.

International Congress of Dermatology

The 12th International Congress of Dermatology will be held in Washington, D. C., September 9-15, 1962. Five dermatological organizations in the United States and Canada will be hosts for the Congress, which will be held in the United States for the first time in 55 years.

The sponsor of the seven-day assembly of specialists in dermatology from 37 countries will be the American Academy of Dermatology. Co-sponsors are the American Dermatological Association, the AMA Section on Dermatology, the Society for Investigative Dermatology and the Canadian Dermatological Association.

Dr. Donald M. Pillsbury of Philadelphia is president of the Congress, and the secretary-general is Dr. Clarence S. Livingood of Detroit.

Dr. C. A. Hoffman To Participate In AUA Panel Discussion

Dr. Charles A. Hoffman of Huntington will participate in a panel discussion which will be presented in connection with the 57th Annual Meeting of the American Urological Association at the Bellevue-Stratford Hotel in Philadelphia, May 14-17.

Doctor Hoffman, who is serving as treasurer of the Association, is a member of a special committee appointed to study socio-economic problems. Results of the study undertaken by the committee will be discussed.

Dr. Donald J. Jaffar will serve as moderator of the panel and the other participants, in addition to Doctor Hoffman, will be Dr. Leonard Martin of Chicago, Director of the Department of Economic Research of the American Medical Association, and Dr. Reed Nesbit, Chief of the Department of Urology at the University of Michigan.

Dr. William B. Rossman, right, immediate past president of the Kanawha Medical Society, accepts a plaque from Dr. Kenneth G. MacDonald, vice president, during the annual dinner dance held recently in Charleston. Dr. D. E. Greenelch of Wheeling (center), president of the State Medical Association, was among the honor guests.

Harry Winston and Hal Herbert Attend AMA Meeting

Harry Winston of Charleston and Hal Herbert of Huntington were among members of the Medical-Dental-Hospital Bureaus of America who attended a meeting in Chicago on February 26, sponsored by the American Medical Association.

Mr. Winston is manager of the Physicians and Dentists Business Bureau in Charleston, and Mr. Herbert is manager of the Bureau in Huntington.

The AMA was host at a reception which was held at the Sheraton-Chicago Hotel on February 25, and the meeting the following day was held at the headquarters offices of the AMA.

The purpose of the meeting was a joint discussion on pending legislation in Congress of mutual interest to members of the Bureau and the AMA.

West Virginia Physicians Commended By State Health Department

Practicing physicians in the state have been commended for their efforts to protect high-risk groups—the aged, those suffering from chronic illnesses, pregnant women and others—by immunizing large numbers of these patients against influenza-like diseases.

Discussing sharp outbreaks in widely scattered sections of West Virginia during the first part of 1962, State Health Director N. H. Dyer said that the high-risk categories accounted for most of the excess mortality during previous epidemics, both locally and throughout the nation.

He noted that manufacturers produced three times the amount of vaccine this season as compared to the year before but "still were not able to keep up with the demand."

Much of the demand for vaccine could be attributed to advance warnings by public health authorities of an expected cyclical upsurge in 1962 and the desire of physicians to protect patients, the health director asserted.

Reporting in the "State of the State's Health," a weekly publication of the State Health Department, Doctor Dyer said 14,912 cases were listed for the first six weeks of 1962—an increase of more than 300 per cent for a comparable period last year. He said that the prevalent type is probably Influenza B, of mild to moderate severity, which has been confirmed in suspect cases in many other states and also noted in specimens submitted to the State Hygienic Laboratory.

Concerning the state's two-year epidemic of infectious hepatitis, Doctor Dyer said the case load is running about the same in 1962 as in 1961—the worst year in departmental records. He observed, however, that the majority of cases involved persons under 20, in which the disease is usually milder than in older age-groups.

Passive immunization of intimate household contacts with immune gamma globulin is still recommended as the best known method of checking the spread of infectious hepatitis, he said.

In another issue of the publication, Doctor Dyer emphasized that tuberculosis remains a major public health problem—"popular opinion to the contrary." He pointed out that there are more than 4,300 known active cases on the departmental register, more than 15,000 cases on the inactive register, and that 714 new cases were uncovered in the state during 1961.

"Despite our efforts at case finding, however, authorities hold that only about 60 per cent of cases are being uncovered and brought to treatment," he said.

"Most experts feel that with new drugs, plus a redoubled effort to find and treat all persons with active tuberculosis so they cannot infect others, we could achieve practical eradication of the disease.

"Until such time, however, as we can muster sufficient funds, personnel and community resources and achieve widespread public understanding of the insidious nature of tuberculosis, we must continue to shoulder the tremendous social and economic consequences of a disease which can be conquered," Doctor Dyer continued.

He said that while new drugs have had a profound effect on tuberculosis death rates, most cases still require months of hospitalization and a year or more of further treatment at home.

For so long as the disease remains a threat of such proportions, the State Health Department will continue to pursue its present policy which requires institutionalization and isolation of infectious cases, he concluded.

Dr. Papanicolaou on AMA Program

Dr. George N. Papanicolaou of New York City will be among the speakers at a meeting of the AMA Section on Preventive Medicine in Chicago on Thursday, June 28.

Doctor Papanicolaou, who developed exfoliative cytology and discovered the "Pap Smear Test" for detecting cancerous and pre-cancerous cells, will discuss some phases of cancer detection.

Cardiac Symposium in Washington

A Cardiac Symposium will be held in the Auditorium of the Medical Society of the District of Columbia in Washington on April 25. The one-day meeting will be sponsored jointly by the Heart Association of Northern Virginia and the Washington Heart Association.

Drs. W. Procter Harvey and James P. Moss are the co-chairmen and they have announced that the following physicians will be among the guest speakers: Drs. Paul Dudley White, Mason Sones, James Warren, George Birch and J. Scott Butterworth.

Physicians in West Virginia have been extended a cordial invitation to attend the meeting. Additional information may be obtained by writing Mrs. Anna C. Van Sickler, Executive Director, 609 N. Edgewood Street, Arlington 1, Virginia.

Limited Funds Available For Heart Research

The West Virginia Heart Association has a limited amount of funds available for research in cardiovascular disease in West Virginia.

Dr. Albert D. Kistin of Beckley, Chairman of the Association's Research Committee, said that that group is charged with the responsibility of investigating, evaluating and reporting on scientific developments in the specific field of heart research.

The Research Committee will recommend the approval of the most desirable projects to the Heart Association's Board of Directors and Executive Committee. Grants-in-aid will be made on a statewide competitive basis with the Research Committee recommending those research projects which indicate the most promising results in the battle against cardiovascular disease.

Complete information and applications are available from the West Virginia Heart Association, P. O. Box 5336, Capitol Station, Charleston, West Virginia.

Booklet on Health Insurance For the Aged Available

The Health Insurance Institute recently published a report of "Guaranteed Lifetime Health Insurance for Persons under and over 65 years of Age."

The report, which is in booklet form, provides an excellent summary of the availability of health insurance plans and policies for persons 65 years of age and over.

It is stated in the foreword that "these health insurance programs help policy holders meet the expenses of both serious and catastrophic illnesses and injuries. They offer a wide range of benefits which can be selected to meet the individual's budgetary situation and health care requirements.

"This report, compiled from material published as of June 1, 1961, contains a broad selection of the many health insurance plans and policies now available which offer protection guaranteed to be renewed for the lifetime of the insured person.

"For those persons who have not as yet reached the senior citizen age, this report also contains many health insurance plans whose guaranteed protection can be carried into their older age. Some of these plans become fully paid-up at 65 years with their benefits continuing for life."

Physicians may obtain copies of the report for distribution to patients by writing the Health Insurance Institute, 488 Madison Avenue, New York 22, New York.

Spring Congress in Roanoke

Physicians in West Virginia have been extended a cordial invitation to attend the 35th Annual Spring Congress in Ophthalmology, Otology, Rhinology, and Bronchoscopy which will be held at the Gill Memorial Hospital in Roanoke, Virginia, April 2-6. Scientific sessions will be held at the Patrick Henry Hotel.

Further information may be obtained by writing Dr. E. G. Gill, 711 Jefferson Street, South, Roanoke, Virginia.

St. Louis Physician Named SMA President Elect

Dr. Daniel L. Sexton of St. Louis has been selected president elect by the Southern Medical Association and will be installed as president of the 15,000-member organization at the 56th annual meeting which will be held in Miami Beach, Florida, November 12-15.

Other officers of the Association are: Dr. A. Clayton McCarty of Louisville, Kentucky, president; Dr. Robert D. Moreton of Ft. Worth, Texas, first vice president; and Dr. Charles Max Cole of Dallas, Texas, second vice president.

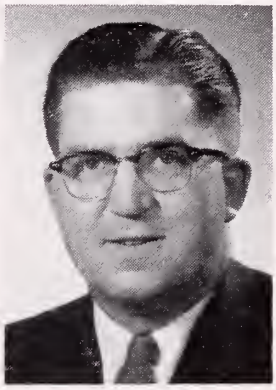
Doctor Sexton was graduated from the University of Notre Dame and received his M. D. degree from St. Louis University School of Medicine. He had postgraduate work at Harvard Medical School and the University of Vienna.

Annual AAGP Scientific Assembly In Las Vegas, April 9-12

Dr. Carl B. Hall of Charleston and Dr. Seigle W. Parks of Fairmont will represent the West Virginia Chapter of the American Academy of General Practice as delegates to the 14th annual scientific assembly of the AAGP in Las Vegas, Nevada, April 9-12.

More than 3,000 physicians are expected to attend the four-day meeting, which will be preceded by a two-day annual meeting of the Academy's policy-making Congress of Delegates. Doctors Hall and Parks will attend the sessions which will be held at the Flamingo Hotel on Saturday and Sunday.

Seigle W. Parks, M. D.



Carl B. Hall, M. D.

The scientific program will open on Monday afternoon, April 9, and the session that afternoon will feature a symposium and panel discussion on geriatric medicine.

One of the features of the meeting will be the appearance of Melvin Belli, the trial lawyer whose fame was made largely in malpractice litigation. He will discuss the legal pitfalls that lurk in the background of medical practice.

In addition to the formal lectures, more than 300 scientific and technical exhibits will be on display in the Exhibit Hall.

The president's reception and dance will be held on Wednesday evening, April 11. Academy officers and their wives will receive guests at this social highlight of the meeting.

Preceding the reception, Dr. James D. Murphy of Ft. Worth, Texas, the president elect, will receive the gavel from Dr. Floyd C. Bratt of Rochester, New York, the retiring president.

Symposium on Cardiovascular Diseases

The 8th Annual Symposium on Cardiovascular Diseases, sponsored by the Heart Association of Louisville and Jefferson County, and the University of Louisville School of Medicine, will be held at the Brown Hotel in Louisville, March 28-29.

The two-day meeting will feature addresses by more than fifteen authorities in the field of cardiovascular disease. Physicians in West Virginia have been extended a cordial invitation to attend the meeting.

Medical Meetings, 1962

The following is a partial list of national, state and district medical meetings scheduled for 1962:

Apr. 9-12—AAGP, Las Vegas, Nevada.
Apr. 12-14—W. Va. Chap. ACS, White Sulphur Springs.
Apr. 23-25—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
Apr. 28-29—Spring Meeting, W. Va. Soc. of Anesthesiologists, Morgantown.
May 25-27—W. Va. Chap. AAGP, Charleston.
June 6-8—W. Va. PH Association, Huntington.
June 24-28—AMA Annual Meeting, Chicago.
June 28-29—Seminar on "The Adolescent," WVU Medical Center, Morgantown.
Aug. 16-18—W. Va. Hospital Assn., White Sul. Springs.
Aug. 23-25—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 13-16—PG Institute, Martinsburg.
Sept. 20-21—W. Va. Heart Assn., Morgantown.
Oct. 22-23—American Cancer Soc., New York.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.

PG Course in Roanoke, Apr. 14-15

Dr. Russell Cecil of New York City will be among the prominent physicians who will present papers at a Postgraduate Seminar on Arthritis and Rheumatic Diseases, which will be held at the Hotel Roanoke in Roanoke, Virginia, April 14-15. The two-day meeting will be sponsored by the Virginia Chapter of Arthritis and Rheumatism Foundation and the Roanoke Branch of the Virginia Chapter.

The registration fee will be $5.00 and the two-day meeting has been approved for Category I Credit by the American Academy of General Practice. Further information may be obtained by writing Miss Amy Van Pelt, Executive Secretary, P. O. Box 45, Roanoke, Virginia.

Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

West Virginia Chapter, ACS, To Meet At The Greenbrier, April 12-14

The annual meeting of the West Virginia Chapter of the American College of Surgeons will be held at The Greenbrier in White Sulphur Springs, April 12-14.

Dr. Robert Coffey, professor of surgery at Georgetown University School of Medicine in Washington, D. C., will be among the guest speakers. The complete program will appear in the April issue of *The Journal*.

The president of the Chapter is Dr. Victor S. Skaff of Charleston, and the other officers are Dr. Francis L. Coffey of Huntington, vice president, and Dr. Jack C. Morgan of Fairmont, secretary-treasurer.

AMA to Meet in Chicago's New McCormick Place

Physicians attending the 111th Annual Meeting of the American Medical Association in Chicago, June 24-28, will view over 700 exhibits and hear scientific papers in the air-conditioned comfort of America's newest and most modern exposition center—McCormick Place.

Doctors who attended the last annual meeting held in Chicago—in 1956—have unpleasant memories of extremely hot, humid weather and poor facilities on the old Navy Pier. Those planning to attend the 1962 meeting are looking forward to their first visit to the new $34,000,000 convention "city" on the lakefront which boasts unobstructed exhibit areas, theaters, attractive restaurants and lounges, shops, and esplanades.

McCormick Place, located on Lake Michigan at 23rd Street, a short distance south of the Loop, is a huge, horizontal structure three blocks long, a block wide and equal to a ten-story building in height. It is fully equipped to handle 30,000 people an hour as they visit exhibits.

Gross exhibit space is 310,000 square feet in the principal section, roughly the area of six football fields. Exhibitors are welcoming the convenient arrangement whereby a train of railroad cars can run inside the building on a special spur for unloading equipment.

There is ample parking for everyone attending the meeting—exhibitors and others in addition to physicians—in huge lots adjoining the building. McCormick Place is a ten-minute taxi or bus ride from the hotel area in the Loop .

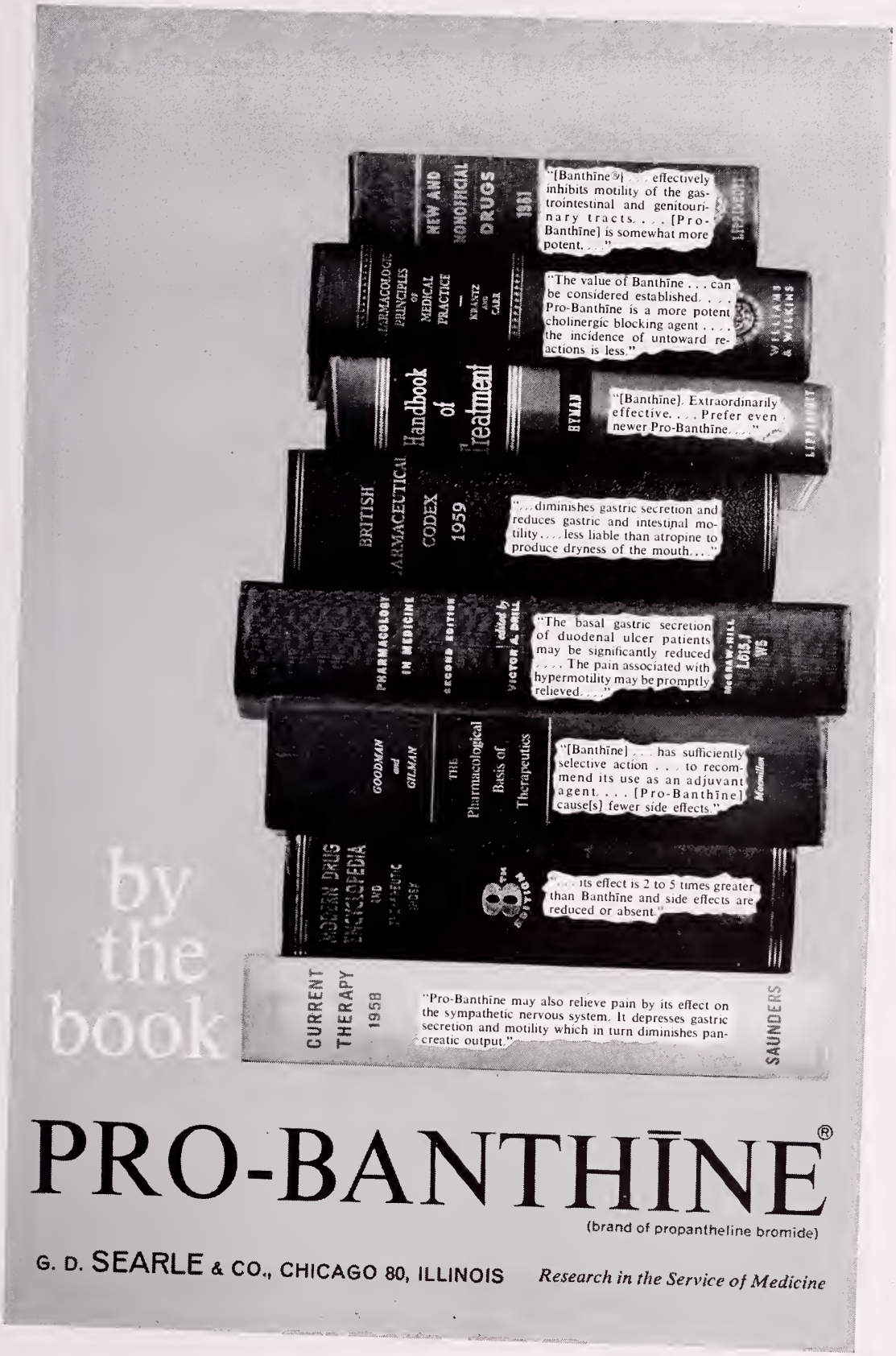
Hotel rooms will be available for everyone. There are 45,700 hotel rooms for guests in the central Chicago area, plus more than 100 hotels in and around the city.

The 1962 meeting will be the first in recent history in which it will be possible to house the entire meeting —scientific sessions, scientific and industrial exhibits, section meetings—under one roof.

Quackery

Today our national, state, and local law enforcement bodies are constantly fighting to protect the public against quackery. We know that the consumer spends more than one billion dollars a year on falsely represented drugs, foods and cosmetics. Five million dollars a year is a conservative estimate of the cost of vitamins and so called health food quackery. Mr. Larrick, Commissioner of Food and Drugs, said in his news release of October 6, 1961, "The most widespread and expensive type of quackery in the U. S. today is in the promotion of vitamin products, special dietary foods, and food supplements. Millions of consumers are being misled concerning their need for such products."

There are many types of quacks, but the hardest to control are the ones with fake medical appliances, pseudo-scientists in nutrition, the self-styled lecturer on nutrition, and those who spread false claims of wonder drugs and fountain of youth cosmetics.—Texas State Journal of Medicine.



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WVU Medical Center
—News—

DR. HARRY T. LINGER of Clarksburg has been appointed Clinical Instructor in Surgery at the West Virginia University School of Medicine. Doctor Linger, who is consultant in ophthalmology at the Clarksburg VA Hospital, will help train WVU medical students at the VA Hospital which cooperates with the University as a dean's committee hospital.

A native of Lost Creek, Doctor Linger was graduated from West Virginia University and received his M. D. degree from the Medical College of Virginia in 1946. He interned at West Baltimore General Hospital, 1946-47, and served a residency at the Episcopal Eye, Ear and Throat Hospital in Washington, D. C., 1950-53.

Medical Center Seminars

Dr. Matt C. Dodd of Columbus was the guest speaker at a Seminar which was held at the Medical Center on January 19.

Doctor Dodd, who is professor of microbiology at Ohio State University, discussed "Experimental Autoimmune Diseases." He was the first to recognize nitrofuran compounds as a distinct class of clinically useful antimicrobial agents and his work served as a cornerstone for the development of several of these compounds, which are useful today in the treatment of certain urinary infections and in the prevention of some dangerous bacterial infections following severe burns.

Dr. Carl J. Witkop, Jr., of Bethesda, Maryland, Chief of the Human Genetics Section of the National Institute of Dental Research, was the speaker at a Seminar held in the Auditorium at the Medical Center on February 2. His subject was "Studies of Hereditary Diseases in Isolates."

Students Receive Scholarships

Thirteen students currently enrolled in the School of Medicine were awarded Avalon Foundation Scholarships totaling $5,460. The awards were made from a grant by the Avalon Foundation of New York in support of the University's Medical Scholarship Fund.

The recipients are Karl V. Metz of Morgantown, C. Marshall Neptune and Edward J. Shahady of Fairmont, Joseph J. Renn, III, of Martinsburg, Ernest G. Sayfie and Paul V. Watson of Charleston, Okey H. Sanford, Jr., of Rainelle, Richard B. Arnold of Huntington, Thomas E. Carter of Bluefield, Donald R. Fowler of Parkersburg, John L. Fullmer of Reedsville, Randall E. Johnson of Williamson and John T. McMurray of Mannington.

• **Compiled from material furnished by Cletis Pride, Public Information Officer, West Virginia University Medical Center, Morgantown, W. Va.**

Research Grants

Dr. Byron M. Bloor, Associate Professor of Surgery and Chairman of the Division of Neurosurgery, has been awarded $35,885 by the National Institutes of Health to support a study of cerebral circulation during the coming year.

Doctor Bloor will attempt to measure and correlate three important aspects of the blood supply to the brain: (1) blood pressure, (2) amount of blood flow, and (3) how much oxygen is being delivered to the brain.

Dr. Robert J. Johnson, Professor and Chairman of Gross and Neurological Anatomy, has been awarded a $29,414 federal grant for research on atherosclerosis in the human vertebral artery. The six-year investigation is supported by the National Institutes of Health.

Doctor Johnson will attempt to learn more about the location and nature of degenerative processes in the vertebral arteries and the relationship of the sites of degeneration to adjacent anatomical structures.

Doctor Johnson, who will be assisted in the study by Royce Montgomery, a graduate student from Montgomery, plans to make direct studies of lesions in the vertebral arteries. The study will deal especially with the relationship of changes in the arteries to the aging process.

The School of Medicine has received $43,389 under a new federal research program. The grant is part of a general research support grant program, recently created within the National Institutes of Health.

Dean Clark K. Sleeth said the grant can be used for any phase of research which will benefit medical students. In some cases, it will finance post-sophomore fellowships, aimed at acquainting the student with the field of medical research. In others, it will help a student who wishes to get in a full year of research and attain an advanced degree.

Dean Sleeth said portions of the grant also can be used for central research facilities, such as a central shop for the maintenance of electronic equipment, which are used by all students doing research. The grant will be administered by the dean and a committee composed of medical faculty members.

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE American Medical Association again endorsed a legislative proposal that the federal government help finance construction of new medical schools and expansion and modernization of existing ones. Dr. Gerald D. Dorman of New York City, a member of the AMA Board of Trustees, told the House Interstate and Foreign Commerce Committee:

"We believe that there is need for assistance in the expansion, construction and remodeling of the physical facilities of medical schools, and, therefore, a one-time expenditure of federal funds on a matching basis is justified, where maximum freedom of the school from federal control is assured."

Doctor Dorman was presenting the AMA position on the Kennedy Administration's 10-year, $932 million program (H. R. 4999) for federal aid to medical education. The legislation also proposed scholarships for medical and dental students.

Adequacy of Physical Facilities

"If the high standards of medical education are to be maintained, increased attention must be given to the adequacy of physical facilities, the availability of qualified instructors and the availability of teaching material and patients for the clinical phases of medical education," Doctor Dorman said. "Any attempt to increase the number of medical students without regard to these conditions will result in a lowering of the standards of medical education. At this time, priority should be given to an increase in the physical facilities available for medical education."

Doctor Dorman said the AMA had not taken a position on the other sections of H. R. 4999. However, he reviewed related AMA programs.

"For some time, the American Medical Association has been aware of the decline in the number of eligible college students seeking admission to medical schools," he said. "This apparent shift away from medicine is due, in part, we believe, to the high cost in time and money of securing a medical education. This trend has been accentuated by a dramatic emphasis on careers in science and engineering.

AMA Programs

"The House of Delegates of the American Medical Association in November, 1960, established two programs, the objectives of which are complementary and interrelated.

"First, the House authorized a student honors and scholarship program designed to focus attention on careers in medicine, to attract a substantial group of able students to prepare for admission to medical schools and to assist financially a limited number of outstanding students, who, for financial reasons, are unable to pursue a career in medicine.

"Second, the AMA House of Delegates has adopted a student loan program designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine."

Doctor Dorman also pointed out that the AMA in the past 10 years, in collaboration with the Association of American Medical Colleges, had aided interested organizations in the establishment of six new medical school.

King-Anderson Legislation

The AMA said it would be irresponsible to combine the King-Anderson bill with legislation that would permit physicians and other self-employed persons to defer federal income tax on income placed in specified private retirement funds.

Sen. Clinton P. Anderson (D., N. M.), co-author of the King-Anderson bill which would provide limited health care for aged persons under social security, suggested the combining tactic during a televised debate on the medical care issue with Sen. John Tower (R., Tex.).

The private retirement legislation—H. R. 10, the Keogh bill—would extend to an estimated 11 million self-employed and their employees the same tax benefits now provided to about 20 million wage earners covered by 66,000 company pension plans.

"This 'doubling-up' proposal of Senator Anderson certainly proves the insincerity of the King-Anderson bill," Dr. F. J. L. Blasingame, Executive Vice President of the AMA, said. "It lays bare the fact that this is wholly a political issue and not a sincere attempt to grant meaningful medical care for the aged.

"The bills have nothing in common. There is no reason whatsoever for combining them except that Senator Anderson is attempting to harass critics of his bill into silence.

"He even calls the Keogh bill the 'doctors' special pension program, ignoring the fact that doctors make up only about 2.6 per cent of those self-employed who would be getting tax equity."

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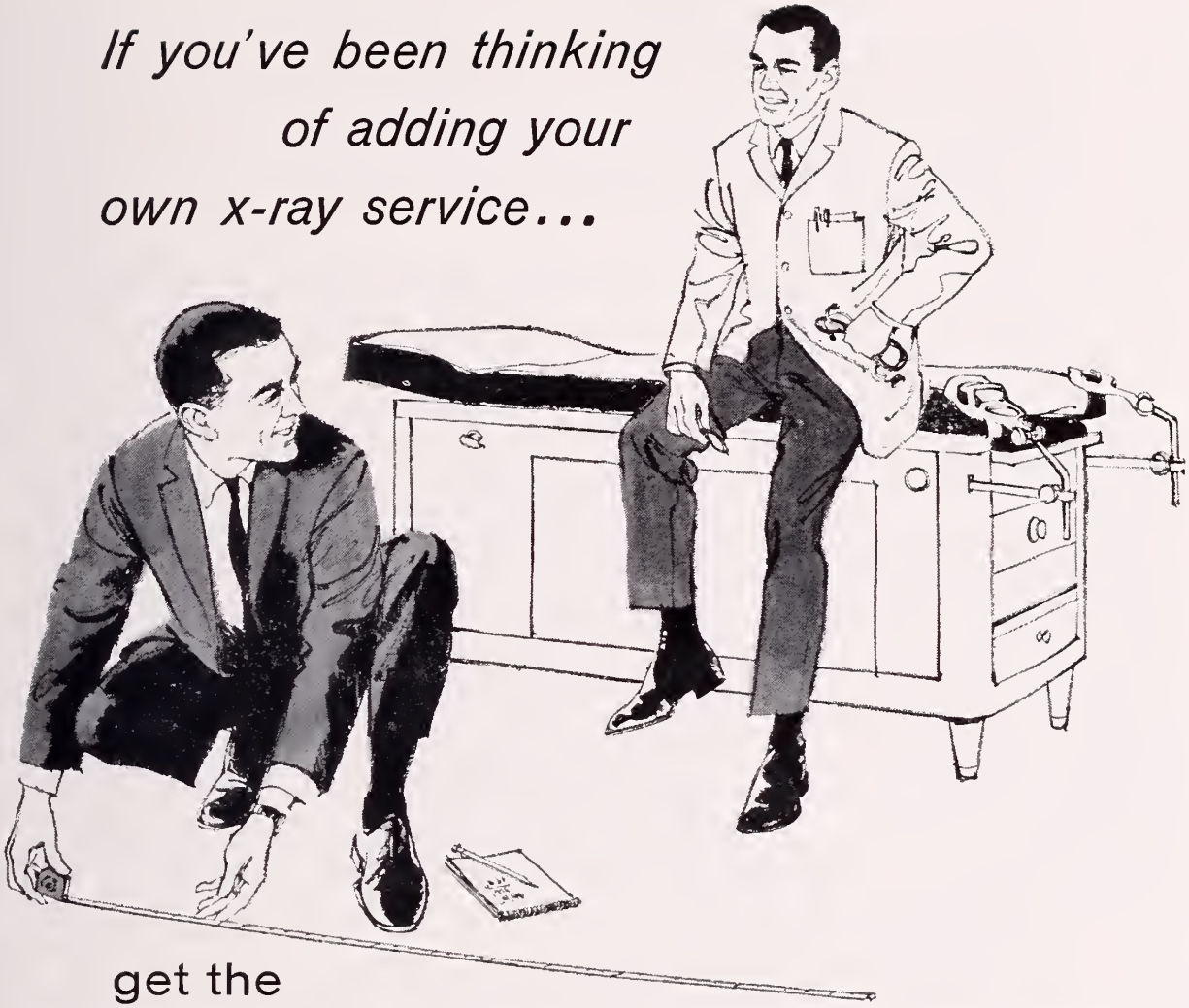

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Obituaries

ELMER ELDEN MYERS, M. D.

Dr. Elmer Elden Myers, 55, of Philippi, died suddenly at a hospital in that community on January 14. Death was attributed to a heart attack.

Doctor Myers, who was recognized as an authority on West Virginia history, was born at Nestorville, Barbour County, on January 11, 1907, a son of Mrs. Lennie Crim Johnson Myers, and the late Dr. J. W. Myers. He was graduated from Broaddus College and attended the two-year School of Medicine at West Virginia University. He received his M. D. degree in 1932 from the University of Pennsylvania School of Medicine.

He interned at the Episcopal and Jeannes Hospital in Philadelphia, 1933-34. He served a residency in laboratory medicine at Pepper Clinical Laboratory, University of Pennsylvania, and also served as instructor in clinical pathology, 1935-36. He was certified by the American Board of Pathology in 1946.

Doctor Myers served as director of laboratories at The Myers Clinic and Broaddus Hospital in Philippi from 1936 until his death. He organized the Department of Medical Technology at Alderson-Broaddus College and served as professor and head of the Department.

Doctor Myers was one of the organizers of the Barbour County Historical Society and served several years as president of that group. He was president of the West Virginia Historical Society, 1950-51, and was named by former Governor Underwood as chairman of the West Virginia Civil War Centennial Commission in 1960.

During World War II, he served for four years as a Captain in the Medical Corps of the United States Army.

Doctor Myers served a term as president of the Barbour-Randolph-Tucker Medical Society in 1949, and was a member of the West Virginia State Medical Association and American Medical Association. He was a Fellow of the American Society of Clinical Pathologists and the College of American Pathologists, and a past president of the West Virginia Association of Pathologists. At the time of his death, he was president elect of the West Virginia Public Health Association.

Besides his mother, he is survived by his wife, Mallador Shaffer Myers; three sons, John William, James Elden and Joseph Michael, all at home; a daughter, Jean Anne, at home; a twin sister, Dr. Edna Myers Jeffreys of Arlington, Virginia; and three brothers, Drs. Karl J. Myers and Hu C. Myers, both of Philippi, and Dr. J. W. Myers of Moundsville.

* * * *

URIAH VERMILLION, M. D.

Dr. Uriah Vermillion, 81, who practiced medicine in Mercer County for more than fifty years, died at his home in Athens on January 28, 1962, following a long illness.

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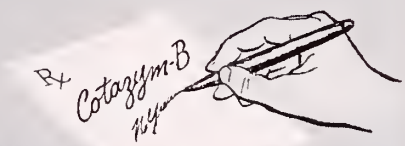

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REFERENCES: 1. Best, E. B., Bightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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Doctor Vermillion was born in Athens on December 16, 1880. He was graduated from Concord College and received his M. D. degree from the University of Maryland School of Medicine in Baltimore in 1909. He was licensed to practice medicine in West Virginia that same year.

Doctor Vermillion served as physician to Concord College from 1917 to 1959, and was a member of the Mercer County Democrat Executive Committee. He served a term as president of the Mercer County Medical Society and was an honorary life member of the West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a son, Dr. Thomas Vermillion of Hampton, Virginia; a daughter, Mrs. Charles K. Baxter of Athens; a sister, Mrs. R. M. French of Beckley; and four grandchildren.

* * * *

EVERETT WALKER, M. D.

Dr. Everett Walker, 93, of Buckhannon, who practiced medicine for many years in Upshur County, died on January 25, 1962.

Doctor Walker was born at Wayne on September 26, 1868, son of the late Doctor Harrison and Amanda Smith Walker. He received his M. D. degree from the University of Maryland School of Medicine in 1904.

He was a member of the staff of the Weston State Hospital for a number of years and served as superintendent of Barboursville State Hospital when it was opened.

Doctor Walker served as president of the Upshur County Medical Society for three years and also served two terms as mayor of Adrian, Upshur County. He was an honorary life member of the Central West Virginia Medical Society, West Virginia State Medical Association and American Medical Association.

He is survived by two daughters, Mrs. Amanda Dickson of Man and Mrs. Charlotte Alderson of Medford, Massachusetts; two sons, James Walker of Baltimore and Joseph Walker of Nitro; eight grandchildren and fifteen great grandchildren.

AHA Meeting in Cleveland, Oct. 26-30

The 1962 annual meeting and scienific sessions of the American Heart Association will be held in Cleveland, October 26-30. The scientific sessions are scheduled from Friday, October 26 through Sunday, October 28.

The deadline for submitting abstracts of papers for presentation at the scientific sessions is May 15. Papers must be based on original investigations in, or related to, the cardiovascular field. Official forms for submitting abstracts may be obtained from Richard E. Hurley, M. D., Medical Associate, American Heart Association, 44 East 33rd Street, New York 10, New York.

Applications for scientific exhibit space are also available from Dr. Hurley. These must be returned not later than May 15, 1962. General information concerning the meetings may be obtained from H. Douglas Chisholm, Associate Director, American Heart Association.

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Robert A. Dye, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brondfoss, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jocob, Jr., M. D.

Psychiatry and Neurology
Albert L. Wanner, M. D.
Stephen D. Word, M. D.
David A. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Barbara Korrer, M. T.

Technologists:
Electrocardiography:
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County Societies

CABELL

Dr. James A. Heckman presided at the regular monthly meeting of the Cabell County Medical Society which was held at the Frederick Hotel in Huntington on February 8.

In response to a request by Doctor Heckman the Society stood for a moment of silent reverence in honor of the late Dr. Walter E. Vest.

Dr. Frank M. Peck, chairman of the program committee, introduced a panel of four local attorneys—Messrs. J. J. N. Quinlan and John Meek, Judge John Hereford and Judge Ernest Winters—who spoke on the role of the physician in medico-legal matters.

These men emphasized that the physician, as a public servant, is duty bound to further to the best of his ability the cause of his patient and of justice. They emphasized that the physician should present his testimony—by letter, in conference with the attorney, or in court, as may be required—in clear, factual, non-technical language and without irritation or anger.

They also added that the physician should show the utmost courtesy and consideration in dealing with the legal profession and with the courts, and they, in turn, will strive to minimize their demands upon his time and service.

Drs. Gerald J. Eder, Joseph E. Chambers and Ronald E. Crissey were appointed as members of a review committee to meet at regular intervals with officials in the district welfare office.

Seventy-one members attended the dinner meeting. —W. L. Neal, M.D., Secretary.

* * * *

KANAWHA

Mr. Borge Rosing of Huntington was the speaker at the annual dinner-dance sponsored by the Kanawha Medical Society at the Daniel Boone Hotel in Charleston on January 13.

Another honor guest was Dr. D. E. Greeneltch of Wheeling, president of the West Virginia State Medical Association, who discussed briefly the MAA program together with legislation of interest to the medical profession now pending in Congress and the State Legislature.

Dr. Robert C. Bock was installed as president of the Society and in his inaugural address he praised the work of the officers during the past year. He succeeded Dr. William B. Rossman.

Other new officers for the coming year are Dr. Kenneth G. MacDonald, vice president, and Dr. Ralph H. Nestmann, secretary-treasurer.

* * * *

MERCER

Dr. Ralph E. Haynes was the speaker at the regular monthly meeting of the Mercer County Medical Soci-

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in the "frantic forties"—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

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In the emergent situation, VISTARIL, administered parenterally, is a valuable aid to the physician in managing patients who escape psychic conflict via alcohol. According to Weiner and Bockman,[2] who obtained beneficial results in 81% of 175 patients studied, hydroxyzine (VISTARIL) may well be considered a tranquilizer of choice in the management of the acutely agitated alcoholic.

1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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ADMINISTRATION AND DOSAGE: Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

SUPPLIED: VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)—10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)—25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)—25 mg. per 5 cc. teaspoonful.

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ety which was held at the West Virginian Hotel in Bluefield on January 15. His subject was "Common Pediatric Problems."

The speaker discussed the above problems under three headings: (1) vitamin administration, (2) treatment of streptococcus throat, and (3) routine immunization. A question and answer period followed the presentation of the paper.

During the business meeting, Dr. Richard Stovall was elected to membership in the Society and Dr. C. R. Hughes was elected to honorary life membership.

Dr. L. J. Pace, president elect of the State Medical Association, presented a report on the recent meeting of the State Council. He discussed several problems in connection with the Medical Aid for the Aged program.

Dr. Joe E. McCary, the president, presided at the dinner meeting which was attended by 37 members and guests.—John J. Mahood, M.D., Secretary.

* * * *

MONONGALIA

Several changes in the constitution and by-laws of the Monongalia County Medical Society were approved during a meeting which was held in Morgantown on January 2.

The changes pertain to election of delegates to the annual meeting of the West Virginia State Medical Association, and the status of membership in the Society.

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The following physicians were elected delegates to the annual meeting at The Greenbrier in August: Drs. Carl E. Johnson, William G. Klingberg and French R. Miller. The alternates are Drs. Robert J. Fleming, Hubert A. Shaffer and Robert Greco.

Dr. C. Truman Thompson, the president, presided at the meeting.—George A. Curry, M.D., Secretary.

* * * *

PRESTON

Dr. J. C. Arnett was elected president of the Preston County Medical Society at the regular monthly meeting which was held at the Howard Hotel in Rowlesburg on January 25.

Other new officers are Dr. Fred A. Kennedy, vice president, and Dr. C. Y. Moser, secretary-treasurer (reelected).

Members of the Woman's Auxiliary also attended the dinner meeting.

Growth in Clinical Research

In the past 15 years there has been a striking growth in clinical research as a two-way bridge between the laboratory and clinical practice. Coupled with this is the achievement of the pharmaceutical industry in the manufacture, quality control, and marketing of new products. In consequence, the lag between scientific discovery and widespread use of new drugs has been shortened.—Luther Terry, M.D., Surgean General, U.S. Public Health Service, to 1961 National Health Forum.

Woman's Auxiliary

to the

WEST VIRGINIA STATE MEDICAL ASSOCIATION

President: Mrs. Vernon L. Dyer, Petersburg
President Elect: Mrs. Howard G. Weiler, Wheeling
First Vice President: Mrs. John W. Hash, Charleston
Second Vice President: Mrs. L. Dale Simmons, Clarksburg
Third Vice President: Mrs. Earl S. Phillips, Wheeling
Fourth Vice President: Mrs. Lee F. Dodds, Huntington
Treasurer: Mrs. Andrew J. Weaver, Clarksburg
Recording Secretary: Mrs. J. A. B. Holt, Charleston
Corresponding Secretary: Mrs. Fred Moomau, Petersburg
Parliamentarian: Mrs. D. E. Greenleltch, Wheeling

KANAWHA

Dr. Willard Pushkin of Charleston was the speaker at the regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society which was held at the Daniel Boone Hotel in Charleston on January 9.

Doctor Pushkin presented an interesting talk on life in a community settlement in Israel. The speaker lived for a year in Israel and based his talk on actual experiences with the people in that country.—Mrs. James B. Nichols, Jr.

* * * *

MERCER

Mrs. Fred Welcker was the guest speaker at the reg-

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ular monthly meeting of the Woman's Auxiliary to the Mercer County Medical Society which was held at the Bluefield Country Club.

Mrs. Welcker, who is educational director for Civil Defense in Mercer County, spoke on the subject, "Survival and You." She stressed helpful points to remember in the event of atomic attack and how to prepare a fallout shelter. She also presented a display of fallout shelter items that would last a family of four for two weeks.

Mrs. William F. Hillier, Jr., the president, presided at the business meeting and the speaker was introduced by Mrs. Dan Pruett.

* * * *

MONONGALIA

Mrs. J. C. Pickett and Mr. John Garlow were the speakers at the February meeting of the Woman's Auxiliary to the Monongalia County Medical Society. Mrs. Pickett discussed progress in the plans for setting up a visiting homemakers service, and Mr. Garlow spoke on mental health.

An honor guest at the meeting was Mrs. L. Dale Simmons of Clarksburg, second vice president of the State Auxiliary. Hostesses were Mesdames Hubert T. Marshall and W. Merle Warman.—Mrs. John J. Lawless, Publicity Chairman.

* * * *

WOOD

Dr. D. E. Greeneltch of Wheeling was the guest speaker at a joint dinner meeting of the Parkersburg

Radiology:
KARL J. MYERS, M. D.

Clinical Pathology:
E. E. MYERS, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Anatomic Pathology:
S. D. WU, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

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LEOPOLDO I. PENA, M. D.
TADAO NAGASHIMA, M. D.

THE MYERS CLINIC
Philippi, West Virginia

Academy of Medicine and the Woman's Auxiliary which was held at the Chancellor Hotel in Parkersburg on January 14.

Doctor Greeneltch, who is President of the State Medical Association, presented an interesting talk on the existing problems in the operation of the Medical Assistance for the Aged program in West Virginia.

Another honor guest was Mrs. Vernon L. Dyer of Petersburg, president of the Woman's Auxiliary to the State Medical Association.

A social hour preceded the dinner meeting and entertainment was provided by students from Parkersburg High School.

Mrs. George Gevas presided at a luncheon meeting of the Woman's Auxiliary to the Parkersburg Academy of Medicine which was held at the Chancellor Hotel on February 13. A local attorney spoke on the subject, "Wills and Estates."

Arrangements for the meeting were under the direction of Mesdames Ralph H. Boice, A. M. Jones, Richard B. Sheridan, Michael A. Santer and Logan W. Hovis. —Mrs. Ira Connolly, Jr., Press and Publicity.

Take a lesson from the woman golfer who—and we have affidavits—faced a downhill lie five yards short of a wide stream the other day. "What club do you think I should use?" she asked her partner. "A seven," came the reply. Our lady looked at the scene again: the ball, the stream, the distant green. "No. I think I'll play it safe," she said, "I'll just carry it across." And she did!

Book Reviews

MECHANISMS OF DISEASE (An Introduction to Pathology) —By Ruy Perez-Tamayo, M. D., Professor and Director of the Department of Pathology of the School of Medicine, National University of Mexico. Pp. 512, with numerous illustrations. Philadelphia and London: W. B. Saunders Company. 1961. Price $14.00.

This is the first edition of a book which contains a vast amount of information in an attempt to integrate present knowledge in the field of "General Pathology" under the concepts of "Mechanisms of Disease." The author has actually arrived at not more than a sketch of such an overwhelming enterprise.

The shortcoming of the book is adequately described by a quotation found in the treatise itself: it needs, ". . . . a more precise description and more penetrating analysis of the data in a more rigorous conceptual frame of reference . . . ."

The different chapters are unequal in quality. Among the best is undoubtedly the discussion of the theories on the "Cause" of cancer (Page 199ff). Up-to-date also is the General Pathology of Connective Tissue, especially the section on Physiology and Formations of Connective Tissue (Page 265 ff). Of great help for the advanced student is the large number of up-to-date references given at the end of each chapter. The list-

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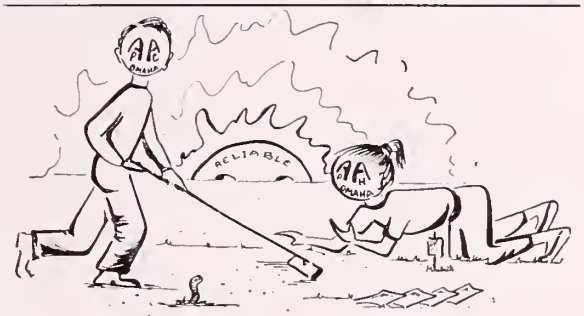

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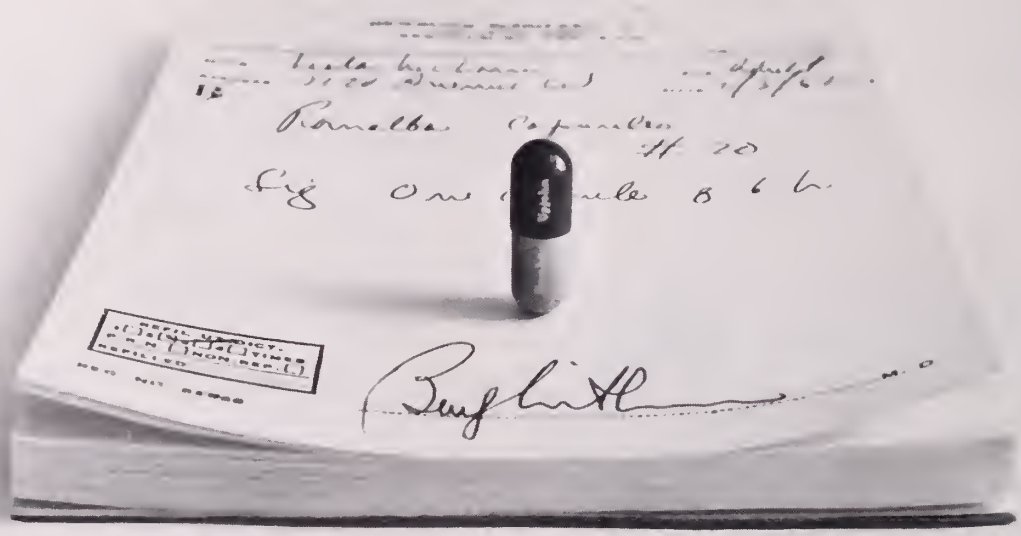

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Panalba* product information

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

Usual Adult Dosage: 1 or 2 capsules three or four times a day.

Side Effects: Panmycin Phosphate is well tolerated clinically and has a very low order of toxicity comparable to that of the other tetracyclines. Side reactions are infrequent and consist principally of mild nausea and abdominal cramps.

Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

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ing of "Paget's Disease of the Nipple" and "Carcinoma-in-situ" under the general heading of "Nonprecancerous Lesions" (Table 26, Page 236), and the discussion of "Acute Yellow Atrophy" of the liver as a true "Atrophy" appear among seriously debatable concepts. Many of the illustrations are inadequate. Few printing mistakes have been encountered. The general appearance of the book is attractive.

A second edition of this treatise is most likely to eliminate most of its shortcomings and make it an asset for the library of interested physicians, students, and pathologists alike.—Peter P. Ladewig, M. D.

Books Received

POSTPARTUM PSYCHIATRIC PROBLEMS—By James Alexander Hamilton, Ph.D., M. D., Associate Clinical Professor of Psychiatry, Stanford University School of Medicine, Stanford, California; Chief of Service, Psychiatry, Saint Francis Memorial Hospital, San Francisco, California. Pp. 156. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Mo. 1962. Price $6.85.

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STRONG MEDICINE—By Blake F. Donaldson, M. D. Pp. 245. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, New York. 1961. Price $3.95.

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PROBLEMS IN SURGERY—By Frank Glenn, M. D., Lewis Atterbury Stimson Professor of Surgery, Cornell University Medical College, New York City; and edited by George E. Wantz, Jr., M. D., Assistant Professor of Clinical Surgery, Cornell University Medical College, New York City. Pp. 512. The C. V. Mosby Company, 3207 Washington Boulevard, St Louis 3, Missouri. 1961. Price $16.50.

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APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY—By John Adriani, M. D., Professor of Surgery, Tulane University School of Medicine, New Orleans, La.; Clinical Professor of Surgery and Pharmacology, Louisiana State University School of Medicine, New Orleans, La.; Director, Department of Anesthesiology, Charity Hospital of Louisiana, New Orleans, La. Pp. 279. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1961. Price $7.75.

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RESPIRATION IN HEALTH AND DISEASE—By R. M. Cherniack, M. D., M.Ss., F.R.C.P. (C), Assistant Professor of Medicine, University of Manitoba School of Medicine; and L. Cherniack, M. D., B.Sc., M.R.C.P. (Lond.), F.R.C.P. (C.), F.A.C.P., Assistant Professor of Medicine, University of Manitoba School of Medicine. Pp. 403, with illustrations. Philadelphia and London: W. B. Saunders Company. 1961. Price $10.50.

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PATHOLOGY—By W. A. D. Anderson, M.A., M. D., F.A.C.P., F.C.A.P., Professor of Pathology, University of Miami School of Medicine and Director of the Pathology Laboratories, Jackson Memorial Hospital, Miami, Florida. Pp. 1389, with 1385 illustrations. Fourth Edition. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Missouri. 1961. Price $18.00.

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INTRODUCTION TO ANESTHESIA (The Principles of Safe Practice)—By Robert D. Dripps, M. D., Professor and Chairman, Department of Anesthesiology, Schools of Medicine, University of Pennsylvania; James E. Eckenhoff, M. D., Professor of Anesthesiology, Schools of Medicine, University of Pennsylvania; and Leroy D. Vandam, M. D., Clinical Professor of Anesthesia, Harvard Medical School. Pp. 413, with numerous illustrations and line drawings by Leroy D. Vandam, M. D. Second Edition. Philadelphia and London: W. B. Saunders Company. 1961. Price $8.00.

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EXECUTIVES' HEALTH SECRETS—By William P. Shepard, M. D., Former Medical Director of the Metropolitan Life Insurance Company. Pp. 268. The Bobbs-Merrill Company, Inc., 3 West 57th Street, New York 19, N. Y. 1961. Price $4.95.

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THE ART OF THINKING—By Dagobert D. Runes, Doctor of Philosophy of the University of Vienna. Pp. 90. Philosophical Library, Inc., 15 East 40th Street, New York, New York. 1961 Price $2.75.

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DISTURBANCES OF HEART RATE, RHYTHM AND CONDUCTION—By Eliot Corday, M. D., Assistant Clinical Professor of Medicine, School of Medicine, University of California, Los Angeles; Attending Staff, Cedars of Lebanon and Mt. Sinai Hospitals, Los Angeles; and David W. Irving, M. D., Clinical Assistant, School of Medicine, University of California, Los Angeles; Research Associate, Cedars of Lebanon Hospital, Los Angeles; Research Fellow, Los Angeles County Heart Association. Pp. 357, with illustrations. Philadelphia and London: W. B. Saunders Company. 1961. Price $8.50.

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PSYCHIATRY—Biological and Social—By Ian Gregory, M.A., M. D., Assistant Professor of Psychiatry and Coordinator of Undergraduate Education in Psychiatry, University of Minnesota Medical School. Pp. 577. Philadelphia and London: W. B. Saunders Company. 1961. Price $10.00.

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CLINICAL OBSTETRICS—By Benjamin Tenney, M. D., Clinical Professor of Obstetrics & Gynecology, Harvard Medical School; and Brian Little, M. D., Associate in Obstetrics & Gynecology, Harvard Medical School. Pp. 440, with illustrations. Philadelphia & London: W. B. Saunders Company. 1961. Price $8.50.

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THE DYNASTY—By Charles Knickerbocker, M. D., Bar Harbor, Maine. Pp. 416. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, New York. 1961. Price $4.50.

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THE ABORTIONIST—By Dr. X as told to Lucy Freeman, New York, New York. Pp. 216. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, New York. 1962. Price $3.95.

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COMMON SENSE ABOUT PSYCHOANALYSIS—By Rudolph Wittenberg. Pp. 216. Doubleday and Company, 575 Madison Avenue, New York 22, New York. 1962. Price $3.95.

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IRRITATION AND COUNTERIRRITATION: A Hypothesis About The Autoamputative Property of the Nervous System—By Adolphe D. Jonas, M. D. Pp. 368. Vantage Press, Inc., 120 West 31st Street, New York 1, New York. 1962. Price $7.50.

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THE SCIENCE OF DREAMS—By Edwin Diamond, Science Editor of Newsweek. Pp. 264. Doubleday and Company, Inc., 575 Madison Avenue, New York 22, New York. 1962. Price $4.50.

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ATLAS OF CLINICAL ENDOCRINOLOGY—By H. Lisser, A.B., M. D., Clinical Professor Emeritus of Medicine and Endocrinology, University of California School of Medicine, San Francisco, California; and Roberto F. Escamilla, A.B., M. D., Clinical Professor of Medicine, University of California School of Medicine, San Francisco, Civilian Consultant and Chief of Endocrine Clinic, Letterman Army Hospital, San Francisco, California. Pp. 489, with numerous illustrations. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Mo. 1962. Second Edition. Price $23.00.

* * * *

TEXTBOOK OF ENDOCRINOLOGY—Edited by Robert H. Williams, M. D., Chief, Endocrinology and Metabolism Division, and Physician-in-Chief, University Hospital, University of Washington Medical School, Seattle; with contributions by twenty-one authorities. Pp. 1204, with illustrations. Philadelphia and London: W. B. Saunders Company. 1962. Third Edition. Price $21.00.

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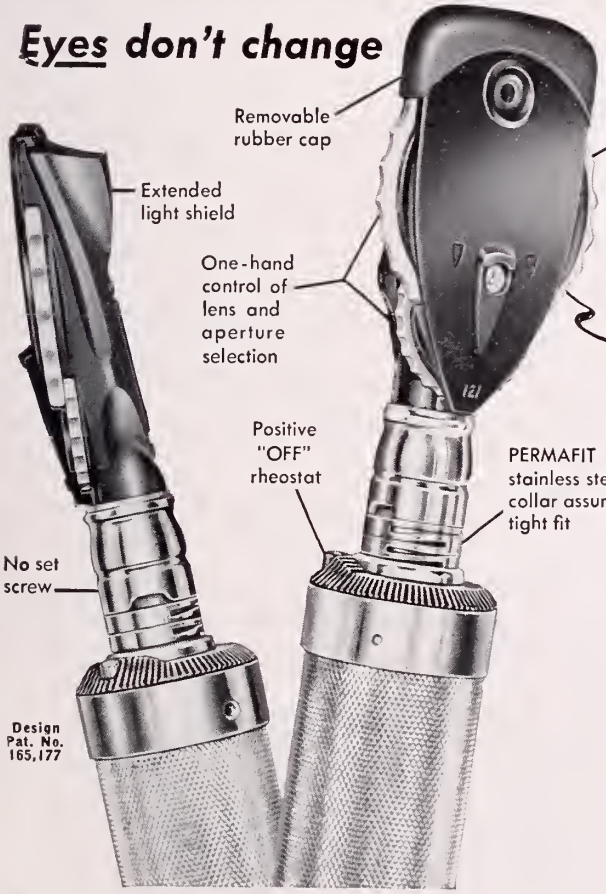

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APRIL
1962

Vol. 58 No. 4

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone Dickens 4-4625.

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The West Virginia Medical Journal

April, 1962 Vol. 58, No. 4

Oral Hypoglycemic Agents*

H. B. Mulholland, M. D., and John A. Owen, Jr., M. D.

Janbon and his co-workers at Montpellier, in 1942, were conducting clinical trials of a new sulfonamide (2254RP, the isopropylthiodiazole derivative of sulfanilamide) in typhoid fever, when they discovered that the drug produced hypoglycemia.[1] Investigation of this effect was carried out by Loubatieres[2] who soon discovered that 2254RP was hypoglycemic only in animals with the pancreas intact and, accordingly, hypothesized that the drug acted on the islands of Langerhans to increase the secretion of insulin. Franke and Fuchs,[3] in 1955, reported that an allied compound, BZ 55 (1-butyl-3-sulfonylurea), produced hypoglycemia in the normal human (Fuchs himself), and immediately there followed reports of its hypoglycemic efficacy in certain cases of maturity-onset diabetes.[4, 5] Drug firms both in Germany and in this country promptly recognized the clinical importance of the discovery and launched extensive clinical trials. BZ 55 (Carbutamide) never was marketed in this country because of toxic dermatoses, bone marrow depression and hepatotoxicity; several patients died as a result of these effects. The drug still is used widely, however, in Germany.

Tolbutamide

Tolbutamide (1-butyl-3-p-tolylsulfonylurea) was under study at the same time and, being relatively nontoxic, became the first hypoglycemic sulfonylurea to be commercially available in this country, and even now probably is more widely used than any other. Tolbutamide is readily absorbed from the gastrointestinal tract and is excreted in the urine in the oxidized form. Since excretion is fairly prompt, and since the pancreatotropic effect is dependent on the sulfonylurea concentration in the blood, it is necessary to administer the drug in divided doses.

The clinician who proposes to use tolbutamide will avoid a great deal of uncertainty, discomfort to the patient, and loss of time and money by a careful selection of patients who are to receive it. Unstable diabetes responds so rarely that it is not worth while to give the drug to such patients. Either a history of severe ketoacidosis or the prompt appearance of intense ketonuria on discontinuing insulin is a good argument against using tolbutamide. The drug is most useful in maturity-onset diabetes occurring after the age of 40; also, disease of short duration requiring less than 40 units of insulin daily has an excellent chance of responding. While obesity is said to characterize the likely candidate for tolbutamide, it is even more likely that weight reduction alone will serve to control the diabetes in such cases (Figures 1 and 2).

The metabolic *sine qua non* for clinical success with these agents, in fact, is the presence of insulin in the beta cells of the islands, and the possibility of its discharge produced by the level of sulfonylurea derivative in the pancreatic arterial blood. This is the situation that exists in the normal person and in the patient with early diabetes of the maturity-onset type; as diabetes

The Authors

- **H. B. Mulholland, M. D., Department of Internal Medicine, University of Virginia School of Medicine, Charlottesville, Virginia.**
- **John A. Owen, Jr., M. D., Department of Internal Medicine, University of Virginia School of Medicine, Charlottesville, Virginia.**

*Presented by Doctor Mulholland before the annual meeting of the Association of Surgeons of the Chesapeake and Ohio Railway at The Greenbrier in White Sulphur Springs, November 17, 1961.

Submitted to the Publication Committee, January 15, 1962.

progresses the dischargeable insulin is progressively exhausted, and in juvenile diabetes it is almost invariably absent from the beginning.[6] Since even a small amount of circulating insulin protects against florid ketoacidosis, a history of this complication is good evidence of total insulin deficiency.

It is customary to begin tolbutamide with a dose of 1.0 Gm. three times daily, giving 1.0 Gm. twice the second day and 0.5 Gm. twice a day thereafter; this establishes a therapeutic blood level of the drug on the first day. Increasing the dose above 1.0 Gm. per day usually does not improve the degree of control further.

Treatment of diabetic patients with tolbutamide requires considerably more attention than does treatment with insulin. Insulin will always reduce hyperglycemia once the proper dose is found. Tolbutamide in any dose is either effective or ineffective. To decide this, the physician must have his criteria of good control clearly established in his own mind and must obtain the necessary laboratory data to decide the point both before and after treatment is begun. The authors have seen many patients blindly started on an oral hypoglycemic regimen which was completely ineffective; these patients have wasted a good deal of money for many months and are sometimes stubbornly resistant to the idea of going back on insulin.

Even if bona fide good control is established with tolbutamide, it seems likely to be impermanent. Trauma, infection, surgery, or fever from any cause may allow diabetes to become uncontrolled; sometimes control can be re-established when the patient returns to status quo, but often this so-called secondary failure is permanent. Many times it occurs without any predisposing factors. Moss[7] and his co-workers analyzed the response of 200 diabetic patients to sulfonylurea drugs and found control to be good or excellent in 49 per cent, unsatisfactory in 17 per cent, and initially good with eventual secondary failure in 16 per cent (Figure 3). Some obese patients did as well on placebos as on sulfonylurea therapy. These observers estimated that 2 to 3 per cent of any group of tolbutamide controlled diabetics will manifest secondary failure each month that therapy is continued.

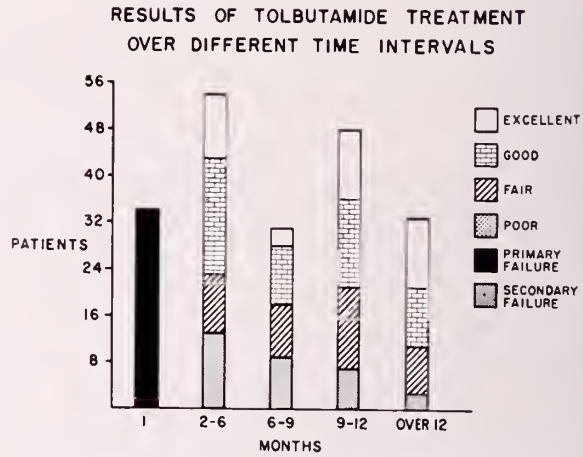

Figure 3—Results of prolonged tobutamide therapy. The persistent occurrence of secondary failure within each time interval is obvious. (Reprinted by permission of Moss et al., Ann. Int. Med. 50:1407, 1959).

Chlorpropamide

Chlorpropamide (1-propyl-3-p-chlorobenzensulfonylurea) is a newer sulfonylurea drug, with a mode of action identical to that of tolbutamide. It has several advantages, however, in that urinary excretion is slower, and comparable control

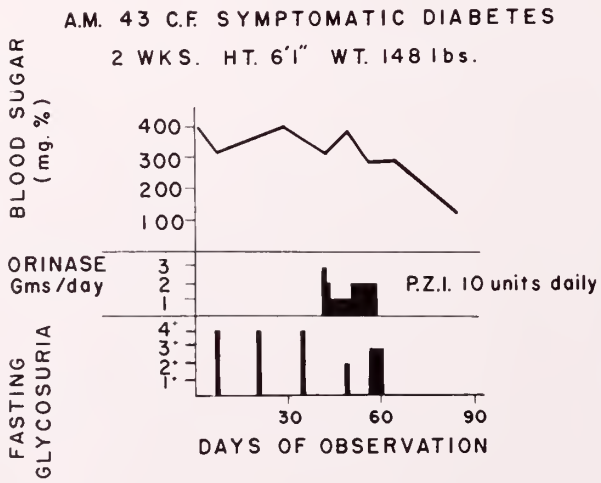

Figure 1—Failure with tolbutamide. This tall and rather slender woman did not respond to tolbutamide administered for three weeks, even though diabetes was of recent onset. She was satisfactorily controlled on a small dose of insulin.

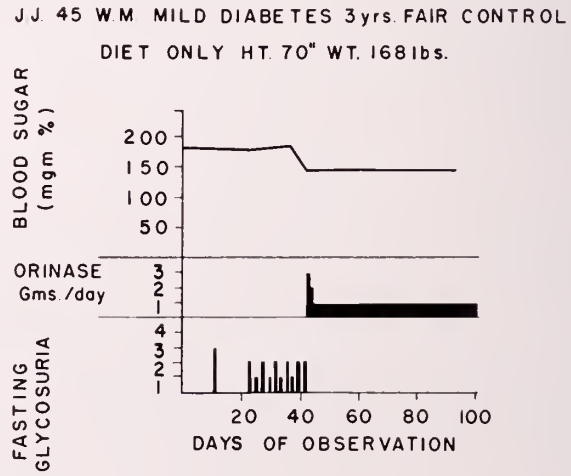

Figure 2—Success with tolbutamide. This patient was in the same age and height group as the patient in Figure 1, but had maintained normal weight on a diabetic diet over a period of three years. Tolbutamide 1.0 Gm. daily produced and maintained good control of diabetes.

of diabetes is possible with a single daily dose of 100-200 mg. Larger doses have been shown to carry a risk of hepatotoxicity. Rarely, it is effective where tolbutamide has failed. A recently published report[8] demonstrates that maturity-onset diabetes requiring more than 50 units of insulin daily often may respond to chlorpropamide. No difficulty was experienced when the change from insulin to the oral agent was made.

Metahexamide

Metahexamide (1 - cyclohexyl - 3 - p - methyl - 4-amino sulfonylurea) was evaluated clinically because of a longer half-life in the body (hence higher potency). Several instances of severe hepatotoxicity developed, however, and the drug was promptly withdrawn from clinical trial.

Acetohexamide

Acetohexamide (1 - cyclohexyl - 3 - p - acetyl-sulfonylurea) recently has been evaluated on our metabolism service. It is similar in action to the older drug, is effective in a single daily dose, and has a potency half-way between tolbutamide and chlorpropamide: 400 mg. per day is equal to 1.0 Gm. of the former or to 150 mg. of the latter. Figure 4 shows the effect of acetohexamide on blood sugar, free fatty acids and cholesterol on the seventh day of therapy in six hospitalized patients, as compared with diet alone, or tolbutamide or chlorpropamide in equivalent doses. Interestingly enough, the 4-hour curve for serum free fatty acids appears to be as accurate and sensitive an index of the degree of control of diabetes as is the curve for blood glucose; cholesterol and total lipids (not shown) are little affected. So far no toxic effects have been noted in eight patients on long-term therapy with acetohexamide.

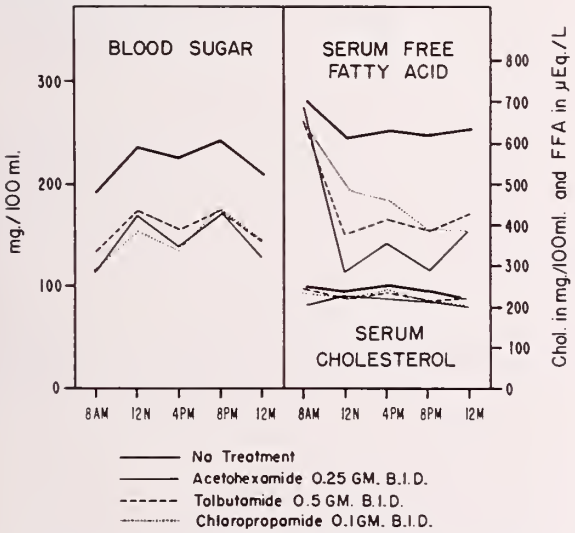

Figure 4—Circadian changes in untreated and treated diabetes. These levels were measured on the seventh day of the control period and of each of the treatment periods for each patient. One patient received only 50 mg. of chlorpropamide b. i. d.

Ayepinamide

Another new drug, ayepinamide, has been reported to be very effective in preliminary trials. We have used it in a few patients who did not respond to other sulfonylurea derivatives, but so far with no benefit. This hardly is a fair test, of course, and comparison with acetohexamide should be of great interest.

Tolbutamide, Young Diabetics and Glucose Tolerance

Fajans and Conn[9] have used tolbutamide in an interesting way in young people with mild diabetes with improvement in glucose tolerance. The patients were not obese but they had mild asymptomatic diabetes mellitus, and most were found to have diabetes as a result of a glucose tolerance test or a combination of cortisone and glucose tolerance test. These individuals, 14 in number, were from 4 to 35 years of age. Thirteen had a strong family history of diabetes. Tolbutamide was given in the amount of 0.5 Gm. in the morning and 0.5 Gm. at night. Some of the patients showed normal glucose tolerance two to four months after the administration of tolbutamide. In six cases, however, the tolerance tests were not normal. The improvement in those cases in which there was response to the drug could not be attributed to diet alone. These individuals showed an increase in blood insulin release after tolbutamide was administered and tolbutamide seemed to increase the island cell function. This is mentioned only as an interesting fact and should be confirmed by others. One should be extremely careful in using sulfonamide drugs in the case of any young person.

Tolbutamide also promises to become of considerable value as a diagnostic agent. Several groups have proposed that the response of blood glucose to the intravenous administration of 1.0 Gm. of sodium tolbutamide be used as a means of separating early diabetes from other states such as advanced age, thyrotoxicosis, obesity and liver disease which also may impair tolerance to oral glucose. Fajans[10] and colleagues recently have pointed out the value of this test in hypoglycemic states, in that the presence of a functioning insulinoma results in a blood glucose response which is quite different from that occurring in hypoglycemia due to any other cause. This innovation promises to save the hypoglycemia patient much time, inconvenience and anxiety over inconclusive tests.

Unanswered Questions

The sulfonylurea drugs have had a profound influence on research in diabetes and metabolism and have provoked re-examination of some of our older ideas as well as opened up entirely new approaches. We have come to realize how little

we know about the early stages of maturity-onset diabetes. How does hyperglycemia coexist with relatively normal insulin content of pancreas and serum? Is there a defect of secretion of insulin or an inhibition of peripheral activity? Do the synthetic compounds stimulate insulin release by a direct means or by increasing the sensitivity of the beta cells to the levels of blood glucose? Do these drugs have an effect on the liver which is not mediated via insulin? Does long-term excellent control of diabetes by sulfonylurea therapy protect against diabetic complications any better than a similar degree and duration of control with insulin? How can we reconcile the apparent protective effect of tolbutamide in patients with mild alterations of glucose tolerance with the discouraging incidence of secondary failure in well established diabetes? Will future sulfonylurea derivatives ever liberate us from the danger of secondary failure? These and many other questions demand better answers than we can give at present.

Levine and Berger[11] have published an excellent review on the use of oral hypoglycemic agents. They mention the fact that Watanabe[12] found that a guanidine compound caused hypoglycemia. Eight years later Frank[13] developed synthalin which, when given orally, produced hypoglycemia but it was found that hypoglycemia brought about by this compound probably was due to liver damage.

Phenethylbiguanide

A new compound with a guanidine base recently has been studied because of its ability to produce hypoglycemia. Phenethylbiguanide, or phenformin, does not affect the release of insulin but appears to have a metabolic effect on the cellular level, stimulating anaerobic glycolysis and the transfer of glucose across the membrane into the cell. The step by step mechanism of action still is unsettled. At any rate, the drug is an effective hypoglycemic agent in doses of 100-250 mg. daily. While it can be shown to have some effect in all diabetic patients, only those with maturity-onset diabetes can safely discontinue insulin. Phenethylbiguanide is not dangerously toxic, but has the unpleasant side-effects of anorexia, nausea and vomiting, which are severe enough to preclude its use in approximately two-thirds of all suitable candidates. The remaining third can achieve satisfactory control on divided doses if the dosage is low at first and increased gradually. Several observers have reported that the combined use of phenethylbiguanide and insulin in unstable diabetes has permitted a smoother course with less abrupt swings in blood sugar. From our limited experience, we can say only that we have not been fortunate enough to obtain this effect. Others report that phenethylbiguanide plus a sulfonylurea will permit control when secondary failure to the latter drug has developed. It may be argued that insulin would be a simpler and less expensive way of controlling the disease in such cases.

Moss and his group[14] recently have reported that long-acting phenethylbiguanide in timed dispersal form permits gradual release and absorption of only small amounts of drug at a time. Patients on this form of therapy are relatively free of nausea and vomiting, and a higher percentage of those beginning treatment are able to obtain satisfactory maintenance doses. This may augur well for future clinical experience with this drug.

Salicylate Derivatives

That salicylates lower the blood sugar has been known since 1875. Diabetic patients with acute rheumatic fever often are able to reduce or discontinue their insulin doses while taking massive salicylate therapy. The average diabetic, however, is unwilling to pay the price of moderate salicylism in order to obtain control of diabetes with aspirin. There is an active search going on for salicylate derivatives that will lower the blood sugar without producing salicylism.

In conclusion, oral hypoglycemic agents are valuable in the treatment of selected cases of diabetes. The physician who uses these agents must select his patients carefully, follow them closely, and be prepared to resume insulin therapy when the situation calls for it. No doubt many new hypoglycemic agents will be developed in the future and some of these may be clearly superior to anything we now have. The ultimate value of these agents in the long range study of the patient with lifelong diabetes remains an unanswered question.

Acknowledgment

The studies on acetohexamide were generously supported by a grant from Eli Lilly and Company. The ayepinamide was supplied by the Upjohn Company.

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The Doctor's Image

Not unlike milady's unmentionables, is the doctor's image showing to his personal and professional disadvantage? Yes, says the AFL-CIO and others dedicated to the proposition of total federal medical care under a compulsory, socialized system. Said the *New York Times* recently, "Today in the United States there is a curious medical contrast: the patient seems fine but the doctor is uneasy." In fact, so much has been said and written about medicine's image that some physicians give undue credence to utterances like that of the *Times*.

All this uproar about the public's regard for doctors is something between a smokescreen and a calculated whispering campaign. It's a poorly kept secret that the Department of Health, Education, and Welfare recently engaged an opinion research organization to measure various professional public images. The doctor rated at the top of the scale so Mr. Ribicoff has found it necessary to use the same tired and frayed speech material in lambasting the AMA and its membership. He was probably disappointed in finding out that the medical Indians on the new frontier are such that the American braves and squaws actually like their medicine men.

Nobody—least of all the doctors themselves—denies that some very few physicians are less than totally concerned about what their patients think of them. It's only reasonable to conclude that out of 250,000 practitioners of medicine, at least a few may be without their medical good conduct medals. And these are a source of deep concern to that vast majority of competent, diligent, and fair doctors.

The acid test of the labor-liberal view of medicine's image finds it sorely wanting in a critical respect: It omits, overlooks, and ignores the public which conceives the image in the first place. It seems that the public can also have its share of unhappy souls who simply can't be pleased. But, all in all, both doctors *and* their patients are pretty good folks and neither group is being influenced by all this image hogwash.

And, by the way, ask any physician or patient what they think of Reuther's, Hoffa's, and Meany's images!—Lawrence W. Long, M. D., in Journal of The Mississippi State Medical Association.

Sporotrichosis: A Case Report

John J. Mahood, M. D., and Clifford D. Reiber, M. D.

SPOROTRICHOSIS is a subacute or chronic granulomatous infection caused by the fungus Sporotrichum schenckii and primarily affecting the skin. Although it has been approximately 63 years since the etiology of the disease was established by Schenck and E. F. Smith, its importance as a serious disease process and the extent of its distribution in the United States have not been fully appreciated until recent years. S. schenckii has been known to be endemic in the North Central United States but in the past decade reports of infection by this organism have come from many parts of the country, from as far west as Utah[1] and as far north as Toronto, Canada.[2]

The clinical and mycologic features of sporotrichosis have been well documented elsewhere.[3, 4] Our case report adds little to the established knowledge of the disease; it is, however, the first case of sporotrichosis reported from Southern West Virginia. In this instance the infection was produced by contact with sawdust used in a mixture with sand and calcium chloride for icy roads.

The absence of known reports of sporotrichosis in West Virginia might suggest that it represents a rare disease in this region. It is felt, however, that this may not be the case but, rather, that the disease occasionally is seen* and not reported, or goes unrecognized. The purpose of this report is to draw attention to the fact that S. schenckii is endemic in West Virginia and that more careful consideration is indicated with regard to its inclusion in the differential diagnosis of chronic ulcerated lesions unresponsive to antibiotics.

Case Report

A. F., a 58-year-old white male truck driver, was first seen in consultation by one of us (J. M.) February 15, 1961, for treatment of a "furuncle" which had not responded to medical nor to surgical treatment. During the latter part of December or early January, he had suffered a minor abrasion of the left wrist while shoveling a mixture of gravel, sawdust and calcium chloride on icy roads in the neighborhood of Flat Top, West Virginia, as part of his duties with the State Road Commission. The abrasion appeared to be healing when, several weeks later, a tender swelling appeared at the site of injury. Within a matter of weeks smaller satellite nodules developed about the forearm, and the original lesion of the wrist became ulcerated (Figure 1).

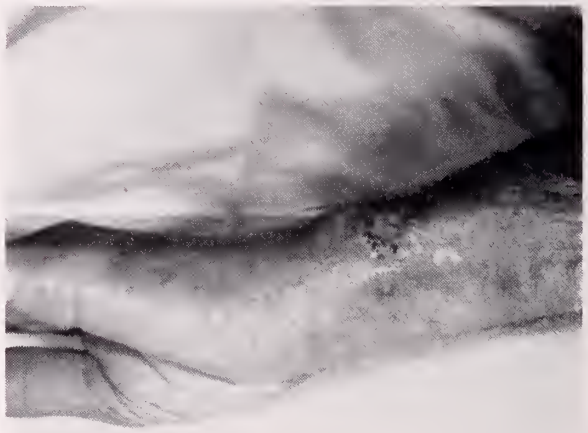

Figure 1. Sporotrichosis. Original lesion and satellite node, the former now ulcerated after several weeks.

The patient had consulted his local physician and was treated with penicillin and other antibiotics without improvement. A nodule had been removed from the forearm on February 4 for study, and a nodule on the volar surface of the forearm above the original lesion was excised a week later. Microscopic sections of both specimens were examined by one of us (C. R.). A diagnosis of "infectious granuloma, etiology undetermined" was made after various special stains (Ziehl-Neelsen acid-fast stain, MacCallum-

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Submitted to the Publication Committee, November 18, 1961.

***Dr. Charles E. Andrews, Associate Professor of Medicine, West Virginia University School of Medicine, was contacted during the preparation of this manuscript. He reports one case seen recently by Dr. J. C. Pickett at Monongalia General Hospital in Morgantown, and another in the Department of Bacteriology at the WVU Medical Center.**

Goodpasture gram stain, Grocott-Gomori methenamine silver nitrate stain and periodic acid-Schiff reaction) failed to reveal identifiable organisms.

Physical examination revealed a large verrucoid ulceration of the left wrist above the head of the ulna. There was a slight sero-sanguineous discharge and the ulcer was surrounded by a purplish-red halo. Five discrete, firm, erythematous nodules were present over the volar surface of the forearm and remains of a recent incision with stitch marks and surrounding elevation and redness were present near the left antecubital space. The epitrochlear and axillary nodes were not palpable. No systemic symptoms were elicited except the anxiety of the patient, and other physical findings were within normal limits.

A fungus infection was suspected and KOH preparation of discharge from the ulcer revealed occasional yeast cells and many polymorphonuclear leukocytes. Treatment was started with potassium iodide, 10 drops, t. i. d., in milk, Epsom salts compresses and tincture of iodine locally.

The patient, however, stopped the potassium iodide orally because of extreme nervousness and gastrointestinal disturbances. The following week he was started on superficial x-ray: 100r once a week for a total of 300r. (Also, at present he is taking potassium iodide enteric coated tablets).

Laboratory Studies

Laboratory studies (performed February 2, 1961) yielded a total leukocyte count of 10,000 per cu. mm., with a normal differential, hemoglobin 16.4 Gm. per 100 ml. and hematocrit of 48 ml. per 100 ml. A fasting blood sugar (Folin-Wu) was 114 mg. per 100 ml. A single culture from the wrist ulcer made on sheep blood agar was reported as "negative after 48 hours."

Bacteriologic examination was carried out on exudate from the wrist lesion on February 15, with inoculation directly on Sabouraud's glucose agar and incubation at 37 C. and at room temperature. Pale yellow colonies appeared in five to seven days in both. The cultures held at room temperature produced growth about two days later than those at 37 C. and the colonies rapidly developed a rough, dry surface, becoming light brown approximately 48 hours after their appearance.

The colonies maintained at 37 C. were smooth and moist but when placed at room temperature also became dry, rough and brown in two to three days. From the cultural and morphologic characteristics the organism was readily identified as S. schenckii. Figure 2 shows the mycelial elements and pyriform conidia.

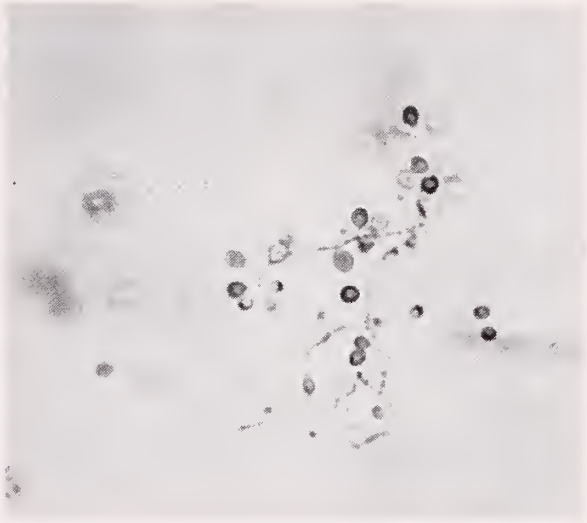

Figure 2. Sporotrichosis. Microscopic section showing mycelial elements and pyriform conidia.

In order to reaffirm this finding, cultures from scrapings and exudate of the same skin lesion were repeated on March 4 and May 17 and, again, S. schenckii was easily grown.

Epidemiologic Study

It occurred to us that in view of the patient's occupation, a possible source of contact with fungus might be one of the constituents of the mixture with which he had been working in cindering roads. Samples were obtained, both of the mixture (gravel, sawdust and calcium chloride) and of the sawdust alone. These materials were then planted on Sabouraud's glucose agar and on Mycocel (BBL), and incubated in much the same manner as that followed when using materials from the wrist lesion.

Cultures of the mixture produced a variety of fungi, but without S. schenckii being identified among them. The sawdust sample, however, yielded S. schenckii almost in pure culture in both media.

The supply of sawdust was found to be from an old sawmill near Surveyor, West Virginia, at a spot called "Whoo-Whoo Hollow." Old, decaying sawdust obtained from this site and cultured on Mycocel agar also produced colonies of S. schenckii, establishing, at least to our satisfaction, this material as the source of the infective agent. It should be stated, however, that animal inoculation studies have not been carried out to date.

Discussion

The majority of cases of sporotrichosis reported in this country, as in the case of our patient, are the localized lymphangitic type. Other variations of the disease, which include involvement of the eye,[5] bone, viscera, (and disseminated[6]), lung[7] and central nervous system[8] are described.

In the localized lymphangitic type, the largest percentage of lesions occur on the extremities or other exposed parts of the body. The organism may gain access through a preexisting break or wound in the skin which becomes secondarily contaminated, or it may be carried directly through the skin by objects such as wood splinters, thorns or broken glass. There also are instances of infection occurring from the bite or scratch of animals.[9] Usually there is a history of minor trauma preceding the appearance of a small, painless pimple or pustule which later ulcerates to form the so-called "sporotrichotic chancre." This is followed by progressive development of nontender nodular lesions along the draining lymph channel. The initial lesion at times also may appear as an abscess or verrucous plaque.

Injury Association.—Most frequently the infection is associated with injury by plant material or wood, since the organism is widely distributed as a saprophyte on various plants and shrubs, and the disease has been termed occupational. Eight cases recently were reported among nursery workers in Florida employed in packing young pine trees in sphagnum moss prior to shipment.[10]

We have not seen reports of infection occurring from known contact with sawdust, but there is no significant difference between the basic composition of wood splinters and sawdust, except in the state in which they might be introduced into the tissues. A remarkable outbreak of sporotrichosis among 2,800 laborers in gold mines in South Africa, which resulted from exposure of the men to infected mine timbers, has been documented.[11]

The sawdust to which our patient was exposed was in a state of decay. It seems likely that the decomposition would enhance its properties as a medium for the fungus, thereby increasing the infectiousness of the material. The organism appears to thrive in decomposing vegetation, being found on a large variety of plants grown in, or associated with, decomposing vegetable matter.

Humidity Element.—Some investigators have felt also that a high humidity may influence favorably the growth of S. schenckii. The largest number of cases, in a report from Uruguay, occurred in the autumn and early winter when the humidity is highest and rainfall most abundant.[12] Although specific determinations of humidity were not conducted in the exact locale from which the sawdust was obtained, the relative humidity for this altitude averages 80 per cent in the southern Appalachian region. The rainfall here also is consistently high through the spring and summer months, averaging 14.5 inches for the three-month period of June, July and August.

Histopathology.—The histopathology depends to some degree upon the type of lesion biopsied and its state of maturation. Typically, one finds a granuloma involving chiefly dermis characterized by focal necrosis or abscess formation encompassed by a margin of epithelioid cells and a few Langhans' giant cells. A dense peripheral infiltrate of lymphocytes and plasmacytes also is present and together with granulation tissue may, in some portions, make up the bulk of the lesion. The picture is quite variable, however, and may consist only of granulation tissue containing a heavy chronic inflammatory cell infiltrate. Pseudo-epitheliomatous hyperplasia of the nonulcerated epidermis is rather constant and may cause one at first to consider a diagnosis of blastomycosis. Tularemia, tuberculosis, syphilis, glanders, pyogenic infections and chemical granuloma, as well as other deep mycoses, must be included in the differential diagnosis.

Lesions of sporotrichosis usually fail to reveal the causative organism in the biopsied tissue, as was our experience. Fetter[13] reports greater success in identifying what appears to be the spore form of S. schenckii, both in specially treated and ordinary PAS stained sections, describing it as a rounded or "cigar-shaped" PAS positive body, predominantly extracellular and occasionally appearing to be encapsulated.

Positive Diagnosis.—A positive diagnosis of sporotrichosis depends upon bacteriologic studies, since the organism cannot be unequivocally identified in exudate or tissue sections. Identification, however, is rather easily established by culture of exudate, scrapings or biopsy material, either from primary or secondary lesions, on Sabouraud's glucose agar or Mycocel (BBL).

Summary

A case of cutaneous sporotrichosis contracted from contaminated sawdust obtained at an old sawmill site near Surveyor, West Virginia, is reported. The clinical and laboratory findings are discussed.

The fact that S. schenckii appears to be endemic in this region should alert physicians to suspect any ulcerating skin lesion which does not respond to adequate antibiotic therapy. The diagnosis can be made readily if material from such lesions is cultured on Sabouraud's glucose agar or Mycocel (BBL).

Acknowledgment

The authors are indebted to Mr. Alva L. Midkiff and Mrs. June Parrish for technical assistance in preparing this report.

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Individualistic Calling

The future of medical practice in the United States may well depend on the decisions made by today's medical students. Their choice of general practice or a specialty, their selection of a particular specialty, may have a profound effect upon a field of human endeavor in which the personal equation is very strong. Despite the changes in society which propel us toward group medicine and tend to impose governmental and other outside controls upon the profession, medicine is still a highly individualistic calling, influenced markedly by the attitudes and aptitudes of its practitioners.

Though this kind of decision is often dictated by circumstances or accident, it may, nonetheless, have a fortunate result. The wiser method is a conscious, well-considered one. As the medical student considers his future career potentials, he must first of all try to know himself. Both general practice and the various specialties offer many opportunities for service to humanity and a fruitful career. But each has differing economic and professional advantages and disadvantages. And each demands different personal qualities from its practitioners. Therefore, the student, looking forward to his career after graduation, should examine his own personality and character in an attempt to estimate his unique needs and abilities. Dedicated as he must be to the service of humanity, he should realize that he can only render his best service in a field which will fully exploit his own capabilities.—Leo G. Rigler, M. D., in The New Physician.

An Analysis of Osteoporosis and Osteomalacia*

C. H. Lee, M. D., and William L. Claiborne, M. D.

Osteoporosis and osteomalacia are confused so frequently that oftentimes when we say osteoporosis we mean osteomalacia, and vice versa. Differentiation of these two entities is distinct but by no means easy. The diagnosis of osteoporosis made by a radiologist from x-ray films frequently is accepted as fact, but when this same radiologist reports osteomalacia he likely will stir up quite a little reaction. To differentiate the two diseases we must start with basic biochemistry.

Bone and the Body Chemistry

The human bone can be compared to a concrete building with steel framework where the framework is called the matrix and the concrete the minerals. A bone adequate in framework but deficient in minerals will be somewhat soft and easily bent. A bone deficient in framework but holding all the minerals it can will be brittle and easily fractured. These conditions account for the basic difference in the radiological picture with regard to the two diseases.

A. *Matrix.*—This is the framework of the bone formed by many substances. Of medical importance are the following:

(1). Protein—a glycoprotein consisting of osseomucoid and osseo-albumoid.

(2). Collagen—intercellular substances.

(3). Vitamin C—needed by collagen.

(4). Osteoblasts—influenced by: stress, activity, estrogen, fracture and repair, and androgen.

Disturbance of the matrix formation results in osteoporosis.

B. *Minerals.*—Formed by many substances, the important ones being: Calcium—Excreted by kidneys, liver and large intestine.

Phosphorus—Excess precipitates calcium phosphate.

Alkaline Phosphatase—Comes from osteoblasts.

Vitamin D—Stimulates renal tubular phosphate reabsorption; activates and lowers alkaline phosphatase; helps intestinal absorption of calcium and promotes local deposition of calcium in bones.

*Presented before a staff conference at The Laird Memorial Hospital, Montgomery, W. Va.

Submitted to the Publication Committee, December 1, 1961.

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Local Alkalinity—Calcium phosphate insoluble and precipitated in alkalinity; alkaline phosphatase needs alkaline environment. Acidosis prevents calcification.

Parathormone—Raises level of serum calcium and promotes renal phosphate excretion. Removes calcium from bone and increases alkaline phosphatase.

Local deposition of calcium in bone probably occurs according to the following reaction: Vitamin D → activates alkaline phosphatase → releases phosphate from its organic compounds → local excess of inorganic phosphates and calcium phosphate formation → precipitation of calcium phosphate in alkaline medium.

Disturbance of the mineral metabolism results in osteomalacia.

Osteoporosis

A matrix disturbance produced by the following:

Immobilization—Lack of stress, hence, lack of osteoblastic activity.

Diabetes—Consumption of protein needed for matrix.

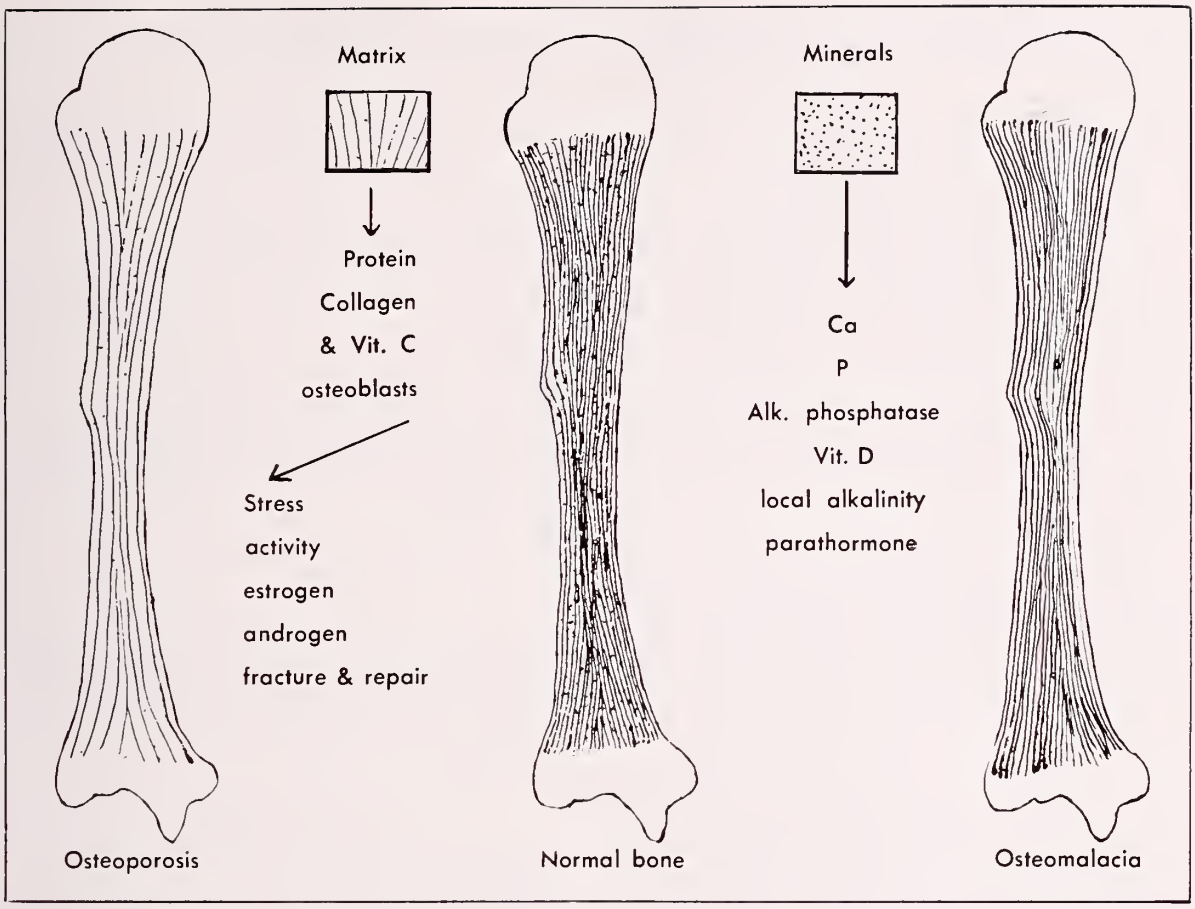
Cortical Steroid Therapy—"Alarm reaction" and Cushing's syndrome—excessive sugar-active hormone with loss of protein. It is of interest to note that in this condition there may be slight elevation of calcium and alkaline phosphatase, suggesting that there may be an element of osteomalacia.

Malnutrition—Lack of protein intake.

Osteogenesis Imperfecta—Osteoblastic enzymatic deficiency.

Postmenopausal and Senile Osteoporosis—Lack of estrogen or androgen.

Scurvy—Vitamin C deficiency.



Nephrosis—Loss of protein through kidneys.

Bone Tumors and Pressure—Preventing matrix formation.

Adrenal Atrophy—Lack of anabolic N hormone.

Hyperthyroidism—Loss of protein. (Elevated alkaline phosphatase probably due to secondary hyperparathyroidism. Therefore, there may be a small element of osteomalacia in hyperthyroidism).

Panhypopituitarism—Multiple endocrine deficiency.

Ovarian Agenesis—Lack of estrogen.

Inflammation — Hyperemia and accelerated bone removal.

Rheumatoid Arthritis—A collagen disease.

Osteomalacia

Disturbance in mineral metabolism produced by the following:

Renal Tubular Dysfunction — Fanconi syndrome—Renal inability to reabsorb phosphate and inability to form ammonia with loss of calcium. Lack of parathyroid hyperplasia because loss of phosphate is not due to parathormone action. Low alkaline phosphatase and low serum phosphorus.

Renal Rickets—Parathyroid hyperplasia, high serum phosphorus, and high NPN. Due to failure of renal phosphate excretion.

Rickets—In immature bone. Low serum phosphate and high alkaline phosphatase. Due to lack of vitamin D. Sometimes due to resistance to vitamin D.

Milkman's Syndrome — Latent osteomalacia with low serum phosphorus.

Osteomalacia—"Rickets in mature bone" due to lack of vitamin D, calcium and phosphorus—biliary fistula, steatorrhea, sprue, fibrocystic disease of pancreas, etc.

Essential Hypercalciuria—Loss of calcium due to low renal threshold. Calcium and phosphorus decreased. Alkaline phosphatase increased.

Hypophosphatasia—Some resemblance to rickets. Normal phosphorus. Calcium may be elevated. Low alkaline phosphatase.

Oxalosis—Formation of calcium oxalate with renal failure.

Renal Failure with Acidosis—Failure to excrete phosphate in urine → elevated phosphorus → lowered calcium and secondary parathyroid hyperplasia.

Multiple Pregnancies and Prolonged Lactation —Loss of calcium.

Poorly Classified Conditions

Hyperparathyroidism—Primary Hyperparathyroidism—mainly osteomalacia. Phosphorus decreased, calcium increased, alkaline phosphatase normal or increased. There is replacement of matrix by fibrous tissue.

Secondary Hyperparathyroidism—Mainly osteomalacia. Phosphorus increased, calcium decreased; alkaline phosphatase normal or increased. Due to failure of renal excretion of phosphates.

Acromegaly—Lack of gonadal hormone, overproduction of thyroid and adrenal cortical hormone (osteoporosis). Growth hormone produces high phosphorus level; serum calcium may be increased; alkaline phosphatase normal or increased (osteomalacia in addition to osteoporosis?).

Paget's Disease—Deossification and excessive repair. Normal calcium and phosphorus. Calcium occasionally elevated. Very high alkaline phosphatase (osteoporosis, osteopetrosis and osteomalacia?).

Sarcoidosis — Hypercalcemia, hypercalciuria, high serum alkaline phosphatase and renal calculi. Osteoporosis(?). Osteomalacia(?).

Hypoparathyroidism — Increased phosphorus, decreased calcium. Alkaline phosphatase normal, increased, or decreased. Entirely separate entity(?).

OSTEOPOROSIS
A MATRIX DISTURBANCE DUE TO DEFICIENCY IN:

	Protein	Collagen	Vit. C	Osteoblastic Activity: Stress and activity	Osteoblastic Activity: Estrogen or androgen
Immobilization				—	
Diabetes	—				
Cortical hormone effect	—				
Malnutrition	—				
Osteogenesis imperfecta				Deficient osteoblastic enzyme	
Senile & Post-menopausal osteoporosis				—	—
Scurvy			—		
Nephrosis	—				
Bone tumors & metastasis	Pressure preventing matrix formation				
Adrenal atrophy	—				
Hyperthyroidism	—				
Panhypopituitarism					—
Ovarian agenesis					—
Rheumatoid arthritis		—			

Pseudohypoparathyroidism — Low calcium. Phosphorus increased. Similar to the above condition, but is due to failure of response to parathormone. Demineralization of bone on x-ray examination.

Differential Diagnosis of Osteoporosis and Osteomalacia

Osteoporosis: Brittle bones and fractures; calcium level usually normal; phosphorus level usually normal; inadequate osteoblastic activity; low or normal alkaline phosphatase; no enlarged parathyroids; x-ray evidence usually noted in spine; frequently asymptomatic until fractures; lamina dura preserved; and adequate mineralization as allowed by deficient matrix.

Osteomalacia: Soft, deformed and bending bones; normal or low serum calcium; low serum

OSTEOMALACIA

A DISTURBANCE IN MINERAL METABOLISM

	Ca	*P*	*Alk. Phosphatase*	*Vit. D*	*Parathyroid Gland Activity*	*Mechanism*
Renal tubular dysfunction	—	—	—		N	Renal loss of P & Ca
Renal rickets	—	+	+		+	Failure of renal phospate excretion
Rickets	N—	—	+	—		Vit. D deficiency
Milkman's syndrome	N—	—	+	—		Vit. D deficiency
Osteomalacia	—	—	+	—		Ca, P & Vit. D deficiency
Essential hypercalciuria	—	—	+			Renal loss of Ca
Hypophosphatasia	N+	N	—			
Renal failure	—	+	+		+	Failure of renal phospate excretion
Oxalosis	—	+	+		+	Renal failure
Pregnancies & prolonged lactation	—	—	+			Prolonged loss of Ca & P
Primary hyperparathyroidism	+	—	N+		+	
Secondary hyperparathyroidism	—	+	N+		+	Renal failure

phosphorus; increased osteoblastic activity; high alkaline phosphatase; enlarged parathyroids; x-ray evidence of pseudofractures usually in extremities; more bone pain and tenderness; absence of lamina dura; and inadequate mineralization in adequate bone matrix.

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Genetic Damage Following Fallout

In the field of the genetic damage following radiation, there is much controversy. The estimates of ultimate damage are made upon the changes that follow radiation to fruit flies and mice. Mutations have been the effects studied. They are alterations in the genetic structure of a species. There is no threshold dose necessary to produce mutations. They can occur spontaneously in every living thing. Naturally occurring background radiation is believed to account for somewhere between 10 and 50 per cent of mutations in humans. Some geneticists have reported mutations following the wearing of tight trousers, producing high gonadal temperatures, and concluded that the mutation rate among the male genes might imply a genetic hazard 100 to 1000 times greater than those estimated from different sources of radiation.

Deductions from experimental data, by investigators in some fields, have been expanded to imply a risk to the race, which is not susceptible of proof. Conservatives in this field, however, have estimated that if the whole population were to receive an average of 10 roentgens per generation for many centuries in addition to natural background radiation, the mutation rate would theoretically increase 20 per cent and would raise the genetically defective population from the figure of 2 per cent to one of 2.4 per cent.

The observed effect of fallout do not agree with the estimated effects. In view of the unsettled state of our knowledge, it seems reasonable to state that we have little to fear from what has passed, and unless the forseeable future brings disaster and radiation far in excess of anything anticipated, we should not live in daily fear of fallout at this time.—Journal of the Louisiana State Medical Society.

The President's Page

Guest Author, Mrs. Vernon L. Dyer, Petersburg, President
Woman's Auxiliary to the West Virginia
State Medical Association

Spring Checks for You and Me

We are told that checks are much in fashion this spring and with its arrival there comes to each of us a desire to get busy. It may be in the tasks that take us out-doors or, usually, we find more things that must be done in cleaning and redoing of the old—along with new additions that help to keep us interested.

It is much this way with our Auxiliary work. This period of the year demands that we check to see just how and where the year has served us. We have many reasons for satisfaction with one of the most pleasant being our liaison with the West Virginia State Medical Association. We consider it an honor to be able to extend to our doctor husbands our sincere thanks for their expressions of appreciation for our Auxiliary efforts and accomplishments. We are pleased that more than 70 per cent of the doctors' wives are members of the Auxiliary.

A new and vigorous approach is being planned for Health Careers. More funds are being given to AMEF through interesting and attractive methods of support. We are striving to project and report the active life of Auxiliary members in Community Service. We need an awareness and a recognition of the many ways the physician's wife labors in her community; in blood-mobile visits, in hospital auxiliaries, in PTA's and in civic and church affairs. These point out only a few of her varied services. An extensive promotion of letter writing has been made by the Committee on Legislation; Mental and Rural Health have received special attention among several organizations; and projects and programs have presented special interests in other Auxiliaries.

The Fall Conference and Board Meeting was held at Moorefield. Many enjoyed a tour of some of the lovely homes in the Potomac Valley. We were most pleased and happy to have with us Dr. D. E. Greeneltch, President of the State Medical Association, and Dr. Clark K. Sleeth, Dean of our Medical School.

The Auxiliary will hold its Spring Conference and Board Meeting in Clarksburg on April 10. On the following day, a statewide officer's training workshop will be conducted for the first time. We are hopeful that all state and county officers will make every effort to attend this day's "togetherness."

Plans are being made for the Annual Meeting in August at The Greenbrier. We appreciate the registration that has been made in the past but we earnestly seek a much larger one this year. Your president desires any suggestions that you may have that will add to our enjoyment and pleasure while attending this Convention.

We take this opportunity to urge *all* doctors' wives to join us in membership and attendance at our meetings. Someone has said, "We cannot kindle unless we glow and when the light is before us, the shadows are behind us." So many have done so much to make this a good year for our Auxiliary.

With sincerest best wishes,

Ruth H. Dyer

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.

EDITORIALS

DECLINE IN MEDICAL SCHOOL APPLICANTS

During the past nine years (1952-1961) there has been a decline in the number of applicants to medical schools.* In 1951-1952 there were 15,920 applicants; in 1955-1956, 14,937; in 1959-1960, 14,952; and in 1960-1961, 14,397. The number of applicants accepted in these years were 7,254; 7,909; 8,512; and 8,660 respectively. It will be noted that only 48 more students were accepted in 1960-1961 than in the preceding year.* This increase was due to the opening of the new medical school at the University of Kentucky.

Medical educators are somewhat concerned about the downward trend in the number of applicants, and earnestly hope that it will not continue. Parenthetically it is of interest that the local situation at West Virginia University currently, and almost surely temporarily, is at variance with the national picture. Presently many outstanding college students are attracted to the field of physics, especially nuclear physics, also to aeronautical engineering, chemistry and mathematics. On the whole, these are more lucrative fields than is the practice of medicine, and the period of training is appreciably shorter.

The great need for many students are sources from which they can borrow money for completion of their medical work. Tuition in many schools has risen astronomically; for example, recently in the *Harvard Alumni Journal* the tuition for the Harvard Medical School was listed for the last 50 years. In 1909 the tuition per year was only $200.00; in 1949 it was $800.00, and in 1958, $1,250.00. These figures are used only as an example. Many other schools, indeed most of them, have increased their tuition substantially.

This means that a student desirous of studying medicine is faced with the fact that his tuition will alone be about $5,000.00 for the four years. Besides tuition, of course, he has to pay for his room, board, books, travel and incidental expenses. The average family is hard pressed to send their child to a medical school.

The establishment of loan funds is needed. Funds should be set up from which the student may borrow. He should be asked to repay the money a year or two after his internship; after that he should be charged a low rate of interest. This fund would then become a revolving fund, and within a relatively short time could be used to aid students in the years ahead. Most medical students are quite responsible persons, and are excellent financial risks. The establishment of such student loan funds would be of inestimable aid and would help attract desirable students to the study of medicine.

*Division of Basic Research of the AAMC, Nov. 1961.

GOVERNMENT AND MEDICAL CARE

Representative Walter H. Judd is not only a long-time member of Congress, but a physician. So he is particularly well qualified to speak on what will happen if the government ever becomes a dominant element in providing medical care.

In a recent talk he said this: "The public has been led to believe that they can get government financing without government control and ultimate government operation of medical services. It is naive for anyone to believe that Congress will take the people's money away from them through taxes and then allow the money to be spent by someone else without the Congress maintaining its own firm control. Congress would be completely irresponsible if it did not so control the funds it raises—and it is not and will not be that irresponsible."

On the specific side, Representative Judd touched on three of the unfortunate results that, in his opinion, would come up with government financing and control. First, the wholly voluntary relationship between doctor and patient would be impaired. Second, the traditional concept of complete privacy with no intermediary between doctor and patient also would be endangered—in his words, "When the doctor gets paid in part or in whole by the government, little by little he comes to work for the government." Third, the incentives which lead doctors to do their best work and to improve themselves would be undermined—and the patient would be the biggest loser.

Call it what you will—government financed medicine, government directed medicine, or socialized medicine—the consequence would be a deterioration of our standards of medical care.—*Clarksburg Telegram.*

Contact Sports and Injuries

The baseball season is here and before too very long the football season will be along with basketball to follow. All of these are bodily contact sports and are part of the growing-up of most American boys. Being contact sports, injuries naturally follow. These seem to be in proportion to the organization of the sport. With this organization, whether it be school, church, or Little League, there is an increase on the part of players, coaches and fans in the desire to win. The game simply for the fun of playing, gives way to rigorous practice and training culminating in a supreme effort in the games against similarly trained teams.

The boys who take part in these sports are in the high school or junior high school group, with efforts even being made to bring organized team sports to younger aged groups to supply better players to the older groups. All of them are in a period of growth and, in many, there muscular and bony development has not stabilized and they are subject not only to the acute injuries of the game but also develop symptoms of chronic strain.

I feel that it is the responsibility of the medical profession of the state to supervise these activities so that injuries may be prevented and those which do occur may be given adequate first aid at the time they happen. At present many of these are handled by coaches and trainers who may well be able to brace an injured ankle or knee so that the boy can go back into the game, but lack of the judgment to know whether he should play or not. The ideal for which we can strive is a "team physician" for each organized team, certainly for each high school group. He should examine the players at the beginning of the season and should know their physical and emotional strengths and weaknesses. He should be interested in athletic injuries and familiar with those usual in each sport and their proper management. Above all he must be a man of character who will place the welfare of the boy before the appeals of coaches, parents, alumni and the player himself rather than have him play when he is not in condition to do so. This is the ideal. The least that we can do is to see that there is a competent physician present at each game ready to give proper emergency treatment.

Contact sports are part of American life. Whether they lead to optimum bodily development or chronic disability which will trouble the player the rest of his life depends on preventive care and proper treatment. This should be the function of the medical profession rather than of laymen and it is the responsibility of each county society to see that the best care is given the players in their own communities.—Richard G. Elliott, M. D., in the Journal of the Kentucky State Medical Association.

Does Money Attract Interns?

The major teaching hospitals are more successful than minor teaching and non-medical-school-affiliated hospitals in obtaining interns. In 1960 they were able to fill 83 per cent of their positions in contrast to 47 per cent and 22 per cent in the other types of hospitals respectively.

Statistics from the National Internship Matching Program show that it is not the amount of stipend paid to the interns. Hospitals paying the smallest amount of stipend ($50 per month or less) with an annual average of approximately 80 per cent of positions filled are the most successful. Furthermore, the popularity of these hospitals has increased during the past eight years. Oddly enough the hospitals paying the most ($200 or more) fell from 61 per cent of the internship positions filled in 1953 to 38 per cent in 1960.

These statistics show that it takes more than money to attract the intern. On the other hand, stipends may enter the picture when hospitals of the same type are being considered. But the non-medical-school-affiliated hospitals cannot expect to compete with the major or minor teaching hospitals by offering more money.—Illinois Medical Journal.

GENERAL NEWS

Drs. Wolf and Riva To Speak At 95th Annual Meeting

Two prominent physicians have been added to the list of guest speakers who will appear on the program at the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25.

Dr. Halvard Wanger of Shepherdstown, Chairman of the Program Committee, announced that Drs. Stewart G. Wolf of Oklahoma City, Oklahoma, and H. L. Riva of Jersey City, New Jersey, have accepted invitations to present papers during the three-day meeting.

Stewart G. Wolf, M. D.

H. L. Riva, M. D.

Doctor Wolf, who is Professor and Head of the Department of Medicine at the University of Oklahoma School of Medicine, will speak at the second general scientific session on Friday, August 24.

Doctor Wolf is a native of Baltimore, Maryland, and was graduated from Yale University. He received his M. D. degree from Johns Hopkins University School of Medicine and served a residency in medicine at New York Hospital. He also served as a Research Fellow in Medicine at Bellevue Hospital and participated in research on head injury and motion sickness with the Harvard Neurological Unit at Boston City Hospital.

He served with the Ninth General Hospital, the affiliated unit of Cornell in Australia, New Guinea and the Philippines during World War II.

From 1946 to 1952, Doctor Wolf served as Assistant and then as Associate Professor of Medicine at Cornell University Medical College. He also was Clinical Associate Visiting Neuropsychiatrist at Bellevue Hospital.

He was named to his present position in 1952. He also serves as Consultant Professor of Neurology and Psychiatry, Head, Psychosomatic and Neuromuscular Section, Oklahoma Medical Research Foundation; and Consultant in Internal Medicine to the VA Hospital in Oklahoma City.

Doctor Wolf is a past president of the American Federation for Clinical Research and served as President of the American Psychosomatic Society in 1961. He received the award of the American Gastroenterological Association for distinguished research in gastroenterology in 1943 and the Hofheimer Prize for research in 1952.

H. L. Riva, M. D.

Another distinguished speaker will be Dr. H. L. Riva of Jersey City, New Jersey, Professor and Chairman of the Department of Obstetrics and Gynecology at Seton Hall College of Medicine. He will appear as a speaker during the third general scientific session on Saturday morning, August 25.

Doctor Riva is a native of Charleroi, Pennsylvania, and was graduated from the University of Pittsburgh. He received his M. D. degree from the University of Pittsburgh School of Medicine in 1939, and served an internship at St. Francis Hospital in Pittsburgh, 1939-40.

He was Chief of Surgical Service at Fort Holabird Hospital in Baltimore, Maryland, 1940-43, and served as Commanding Officer and Chief of General Surgery with the 28th Portable Surgical Hospital, 1943-46.

He served a residency in obstetrics and gynecology at Walter Reed General Hospital, 1946-49, and was Chief of Obstetrics and Gynecology at Walter Reed from 1949 to 1961.

Doctor Riva served as Clinical Associate Professor of Obstetrics and Gynecology at Georgetown University School of Medicine, 1957-61; Consultant in Obstetrics and Gynecology to the Surgeon General, United States Army, 1952-61; and Consultant in Obstetrics and Gynecology to the White House, 1953-61.

He was certified by the American Board of Obstetrics and Gynecology in 1949 and he is a member of the American Medical Association, American College of Surgeons, and the American College of Obstetricians and Gynecologists.

Doctor Riva is a charter member of the International Correspondence Society of Obstetrics and Gynecology, and was elected an honorary member of the West Virginia Obstetrical and Gynecological Society in 1959.

Program Nearing Completion

The Program Committee announced previously the names of two guest speakers, Dr. I. S. Ravdin, Professor of Surgery and Vice President for Medical Affairs at the University of Pennsylvania, and Dr. Irving S. Wright, who is Professor of Clinical Medicine at Cornell University Medical College.

Another speaker will be Dr. George M. Fister of Ogden, Utah, who will be installed as president of the American Medical Association in June. He will speak before the final session of the House of Delegates on Saturday afternoon, August 25. Besides Doctor Wanger, the other members of the Program Committee are Drs. George P. Heffner of Charleston and Charles D. Hershey of Wheeling.

Further details concerning the annual meeting, including the names of other guest speakers and programs for section meetings which will be held afternoons during the three-day meeting, will appear in future issues of *The Journal*. The complete program will be published in the Convention Number in August.

Dr. J. P. McMullen Reappointed

Dr. James P. McMullen of Wellsburg has been reappointed as a member of the National Foundation's Health Scholarship Committee for West Virginia. He is a past president of the West Virginia State Medical Association.

The appointment of Doctor McMullen was announced recently by Dr. Thomas M. Rivers, vice president-medical affairs of the National Foundation.

Doctor Zimmermann Presents Paper

Dr. Bernard Zimmermann of Morgantown participated in the 15th Annual Stoneburner Lecture Series which was held at the Medical College of Virginia in Richmond, March 21-23.

Doctor Zimmermann, who is Professor and Chairman of the Department of Surgery at the WVU School of Medicine, presented a paper on "Diagnosis and Management of Aldosteronism."

Rheumatic Fever Prevention Program

More than 1,500 persons in West Virginia are receiving free penicillin through the rheumatic fever prevention program of the West Virginia Heart Association and the State Department of Health. This is an increase of 206 over last year's figure.

Under the program, penicillin is available to medically indigent patients and distributed upon request of a licensed physician. It is distributed to persons, mostly children, who have had a known attack of rheumatic fever or who have known rheumatic heart disease, cardiac surgery or congenital heart disease of such magnitude that the referring physician deems prophylaxis advisable.

Approximately 20 per cent of the Heart Association's operating budget for the current fiscal year is earmarked for the rheumatic fever prevention program.

West Virginia Chapter, ACS, To Meet At The Greenbrier, April 13-14

The Annual Meeting of the West Virginia Chapter of the American College of Surgeons will be held at The Greenbrier in White Sulphur Springs, April 13-14. Dr. Victor S. Skaff of Charleston, the president, will preside at the two-day meeting.

Robert J. Coffey, M. D.

The principal speaker will be Dr. Robert J. Coffey of Washington, D. C., Professor of Surgery at Georgetown University School of Medicine. Doctor Coffey will present two papers during the meeting: "Experiences in the Diagnosis and Treatment of Hyperparathyroidism," and "A Reevaluation of Treatment of Pancreatic and Periampullary Tumors."

Papers will also be presented by several West Virginia surgeons. The speakers and their subjects are as follows:

"Modern Concepts in the Treatment of Colon Polyps."—Julius L. Berkley, M. D., Charleston.

"Intensive Treatment Unit."—Walter H. Gerwig, M. D., Clarksburg.

"Presentation of an Interesting Case."—William D. McClung, M. D., Charleston.

"Treatment of Peripheral Arterial Occlusions and Aneurysms."—W. R. Wilkinson, M. D., Huntington.

"Thoracic Injuries."—Herbert E. Warden, M. D., Morgantown.

"Pseudocyst of the Pancreas."—Robert Bradley, M. D., Huntington.

Dr. Francis L. Coffey of Huntington, the program chairman, also announced that residents and interns in hospitals throughout the state have submitted papers for possible presentation during the meeting. Authors of two papers judged winners will appear on the program.

A cordial invitation to attend the meeting has been extended by the West Virginia Chapter to all practicing physicians in the state. Scientific sessions will be held during the morning hours and the afternoons will be left open.

Additional information concerning the meeting may be obtained by writing to Dr. Victor S. Skaff, Brooks Medical Building, Charleston, West Virginia, or Dr. Jack C. Morgan, 1120 Locust Avenue, Fairmont.

Doctors in Service

Dr. Clinton L. Rogers of Keyser has been called to active duty with the Medical Corps of the United States Air Force and is stationed at the Base Hospital, Sheppard Air Force Base, Wichita Falls, Texas. His rank is Captain.

New Association Members

Dr. Marion Korstanje, Jr., 1220 Fifth Avenue, Huntington (Cabell). Doctor Korstanje, a native of North Kenova, Ohio, was graduated from Centre College and received his M. D. degree from the Ohio State University School of Medicine in 1955. He interned at St. Mary's Hospital in Huntington, 1955-56, and served a residency at the University of Louisville Hospital, 1958-61. He served with the Medical Corps of the United States Navy, 1956-58. His specialty is ophthalmology.

* * * *

Dr. Alfonso Morales, 1040 Murdoch Avenue, Parkersburg (Parkersburg Academy). Doctor Morales was born in Nvevo Laredo, Mexico, and received his M. D. degree from the University de Nvevo Leon in 1956. He interned and served a residency at Camden-Clark Memorial Hospital in Parkersburg, 1956-58. He was licensed to practice in West Virginia in 1961 and was previously located at Grace Hospital in Welch. He is engaged in general practice.

* * * *

Dr. Walter H. Moran, Jr., WVU Medical Center, Morgantown (Monongalia). Doctor Moran, a native of Grand Forks, North Dakota, was graduated from the University of North Dakota and received his M. D. degree from Harvard Medical School in 1955. He interned at the University of Minnesota Hospitals, 1955-56, and served residencies there and at the WVU Hospital, 1956-61. He served as a First Lieutenant in the Medical Corps of the United States Army Reserve, 1956-60. His specialty is general surgery.

* * * *

Dr. David H. Williams, 722 First Huntington National Bank Building, Huntington (Cabell). Doctor Williams was born in Girard, Ohio, and attended the two-year School of Medicine at West Virginia University. He received his M. D. degree from Cornell University Medical College in 1949 and interned at St. Luke's Hospital in Cleveland, 1949-50. He served as a Captain in the Medical Corps of the United States Army, 1950-53, and practiced in Itmann, Wyoming County, 1953-58. He served a residency in radiology at the University of Virginia Hospital, 1958-61.

* * * *

Dr. Bernard Zimmermann, WVU Medical Center, Morgantown (Monongalia). Doctor Zimmermann, a native of St. Paul, Minnesota, was graduated from Harvard University and received his M. D. degree from Harvard Medical School in 1945. He served an internship at Boston City Hospital and continued his postgraduate training at the University of Minnesota Medical School where he received a Ph.D. degree in surgery in 1953. He served as Head of the Experimental Surgery Facility at the Naval Medical Research Institute in Bethesda, Maryland, 1946-48, and was previously a Professor in the Department of Surgery at the University of Minnesota Medical School.

A sound education must include learning to know when one should differ from his fellow men.—Paul Woodring.

Several Medical Meetings Planned During Seattle World's Fair

West Virginia physicians and their families who plan to visit the Seattle World's Fair have been extended a cordial invitation to coincide their trip with the 73rd Annual Meeting of the Washington State Medical Association in Spokane, September 16-19.

Three full days of scientific programs are scheduled with nationally-known guest scientific speakers, medical television, specialty sessions and general sessions included. For additional information on the program and hotel reservations in Spokane and Seattle, contact the Washington State Medical Association, 1309 Seventh Avenue, Seattle.

The dates of the Seattle World's Fair are April 21 to October 21, 1962, and information is available from the Washington State Medical Association on scientific meetings scheduled in the state during that time. For hotel reservations in Seattle during the Fair, contact Expo Lodging Service, Seattle World's Fair, Seattle 9, Washington.

Physicians File as Candidates For Senate and House

Several physicians have filed as candidates for the State Senate and House of Delegates and their names will appear on the ballots in the primary election which will be held on Tuesday, May 8.

Dr. T. G. Matney of Peterstown, who has served four terms in the House as a delegate from Monroe County, is seeking reelection.

In Kanawha County, Dr. Richard A. Lewis is a candidate for the Senate from the eighth district. Drs. A. B. Bowyer, Carl B. Hall and Charles E. Staats are candidates for the House of Delegates. Mrs. John W. Hash, wife of the immediate past president of the State Medical Association, is also a candidate for the House.

Reprints Needed

The Research Library of the Institute of Experimental Medicine and Surgey of the University of Montreal recently suffered extensive losses owing to destruction by fire.

Dr. Hans Selye, the Director, has asked physicians who have contributed scientific articles to The Journal to send all available reprints of their work, especially those dealing with endocrinology and stress.

Doctor Selye also announced that their permanent mailing list was destroyed and that it will be possible to send reprints of their publications only to those persons who write directly to the Library.

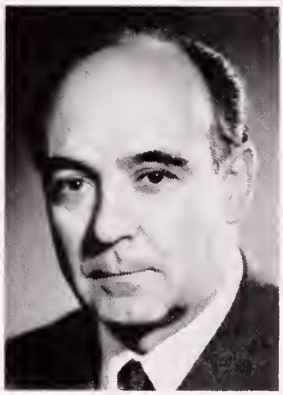
Correspondence should be directed to the Institute of Experimental Medicine and Surgery, University of Montreal, P. O. Box 6128, Montreal, Canada.

W. Va. Acad. Oph. and Otol. To Meet At The Greenbrier, April 23-25

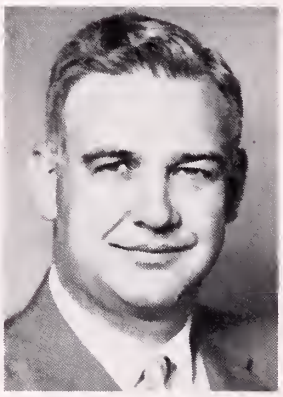
The 15th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held at The Greenbrier in White Sulphur Springs, April 23-25. Dr. Albert C. Esposito of Huntington, the president, will preside during the three-day meeting.

The Academy will entertain early arrivals on Sunday evening, April 22, and the registration desk will open at 2 P. M. on Monday, April 23. Several committee meetings have been scheduled that afternoon and a social hour will be held that evening.

The first general scientific session will be held on Tuesday morning, April 24, following an address of welcome by Doctor Esposito at nine o'clock.



Ramon Castroviejo, M. D.



Fred R. Guilford, M. D.

The guest speakers and their subjects are as follows:

"Dacryocystorhinostomy."—Kelvin A. Kasper, M. D., Chief of the Otological Service at Wills Hospital in Philadelphia, and Chief Clinical Assistant in Otology at Jefferson Medical College Hospital.

"Cataract Surgery—Usual and Unusual Procedures."—Ramon Castroviejo, M. D., Clinical Professor of Ophthalmology at the New York University Postgraduate Medical School, and Chief of the Ophthalmological Service at St. Vincent's Hospital.

"Selection of Cases for Tympanoplasty."—Fred R. Guilford, M. D., Chief of the ENT Service at St. Joseph's Hospital in Houston, Texas, and Associate Clinical Professor at Baylor University School of Medicine.

"Surgery of the Inferior Oblique."—Frank D. Costenbader, M. D., Senior Attending Ophthalmologist at Children's Hospital and Washington Hospital Clinic in Washington, D. C.

"Advanced Techniques of Contact Lens Fitting." —Mr. Philip Salvatori of Obrig Laboratories.

The Academy will serve as host at a social hour which will be held on Tuesday evening prior to the dinner hour.

The second and final general scientific session will be held on Wednesday morning, April 25. The following program will be presented:

"Keratoplasty—Instrumentation, Results and Techniques."—Ramon Castroviejo, M. D.

"Paranasal Sinuses and Associated Orbital Lesions."—Kelvin A. Kasper, M. D.

"Secondary Strabismus Surgery."—Frank Costenbader, M. D.

"Technique of Tympanoplasty."—Fred R. Guilford, M. D.

A business meeting and election of officers will be held following the second scientific session on Wednesday morning. Officers of the Academy are as follows:

Dr. Albert C. Esposito of Huntington, president; Dr. William K. Marple of Huntington, president elect; Dr. James T. Spencer of Charleston, vice president; Dr. Worthy W. McKinney of Beckley, secretary-treasurer; and Drs. R. Alan Fawcett of Wheeling and Ralph W. Ryan of Morgantown, directors.

A cordial invitation to attend the meeting has been extended by the Academy to all practicing physicians in the state. The registration fee for non-members will be $25 which includes the scientific program, social hours and other Academy functions.

A special entertainment program has been planned for wives of physicians attending the meeting.

Further information concerning the meeting may be obtained by writing Dr. Worthy W. McKinney, Secretary-Treasurer, Professional Park, Beckley, West Virginia.

OSMA Meeting in Columbus

The annual meeting of the Ohio State Medical Association will be held in Columbus, May 14-18. Scientific sessions will be held at Veterans Memorial Building and the headquarters hotel will be the Neil House.

Further information concerning the program may be obtained by writing the Ohio State Medical Association, 79 East State Street, Columbus 15, Ohio.

Heart Association To Sponsor PG Course in Cleveland

A postgraduate course on the basic physiology and psychology of work relating to cardiovascular patients will be held at the Tudor Arms Hotel in Cleveland, Ohio, June 18-22. The course will be sponsored jointly by the American Heart Association, the Cleveland Area Heart Society, the USPHS and Western Reserve University.

The objective of the course, to be conducted as a workshop limited to 150 participants, will be to explore the problem of assessing medically the physical types of activity suited to an individual with heart disease, the factors involved and how to determine them.

Laboratory facilities of the University and affiliated hospitals will be utilized for field visits during the sessions, and the practical course will include lectures, demonstrations, individual participation and testing, problems and group discussion.

Further information may be obtained by writing to the West Virginia Heart Association, Box 5336 Capitol Station, Charleston, West Virginia.

Report on Study of Deaths From Heart Disease

An analysis of mortality data seems to confirm a relationship between deaths from heart disease and environmental stress, according to State Health Director N. H. Dyer.

Commenting on results of a five-year study in the health department's "State of the State's Health," Doctor Dyer noted that nearly 54 per cent of deaths from heart disease, for the period 1956-60, occurred during the six cold months from November through April. Also that nearly 19 per cent of the deaths were recorded for January and February, with more than 36 per cent of deaths listed for the four months from November through February.

He said the data are even more significant, considering that the upsurge in mortality from heart disease during cold months is relatively constant in a year-by-year analysis.

The health director observed that the results seemed to confirm suspicions of physicians who warn patients against unusual physical exertion during winter months and caution against overexposure to cold or battling stormy weather, even in the absence of snow, which can be overtaxing to susceptible individuals and bring about heart attacks.

During the five-year period, a total of 33,056 resident deaths were attributed to heart disease.

By the end of the first week in March, Doctor Dyer reported that the State Health Department had recorded 32,134 cases of influenza-like diseases, or nearly six times the case-load for the same period in 1961.

While most cases seem to be of moderate to mild severity and probably Influenza B, which has been confirmed in many surrounding states and in some tests by the State Hygienic Laboratory, Doctor Dyer said there was associated with the disease widely scattered but sharp outbreaks of gastroenteritis.

He said the State Health Department had unconfirmed reports of some deaths in West Virginia from gastroenteritis and reports from at least three other states of deaths among children which were linked to a relatively mild respiratory illness followed by gastroenteritis.

One neighboring state reported cases of children who were hospitalized within six to twelve hours after the onset of vomiting and diarrhea, but "despite therapy progress of the patients could best be described as steadily downward," the physician explained.

As a result of this complicating factor, Doctor Dyer said his department has urged parents to consult their physicians promptly in all cases involving vomiting and diarrhea in children.

Writing in another issue of the departmental publication, Doctor Dyer announced that 84 gross of 50 cc vials of Vitamin A-D-C drops had been purchased for distribution to needy infants and preschool children through local health departments.

He said that the vitamins will provide therapy for 90 days for more than 12,000 of the state's children and are intended primarily for indigent infants on formulas deficient in essential elements.

Allocation to counties was made on the basis of population and economic status and local health officers will distribute the vitamins according to the method deemed best in each area, Doctor Dyer explained.

ACCP Establishes Loan Fund For Resident Physicians

The American College of Chest Physicians has established a fund providing for loans to resident physicians to stimulate interest in postgraduate study of chest diseases and to assist postgraduate students in continuation of studies in diseases of the chest (including diseases of the heart and lungs).

Physicians who have completed an internship of one year or more in an acceptable hospital may apply for a loan to continue in the specialty of chest diseases.

Further information may be obtained by writing the American College of Chest Physicians, 112 E. Chestnut Street, Chicago 11, Illinois.

"The Medical Care Issue—Pro and Con—On the Federal Level" was the subject of a debate at the YWCA in Charleston on February 26. The speakers were Dr. William O. LaMotte, Jr., of Wilmington, Delaware, right, and Ivan A. Nestingen of Washington, Undersecretary of the Department of Health, Education and Welfare. Shown with the speakers are Dr. D. E. Greeneltch of Wheeling, president of the State Medical Association, and Dr. Robert C. Bock, president of the Kanawha Medical Society (Photo courtesy of the Charleston Daily Mail).

Ob. and Gyn. Examinations

The American Board of Obstetrics and Gynecology has announced that new and reopened applications, and requests for re-examination in 1963 will be accepted up to July 1, 1962, which has been advanced from August 1. Candidates are urged to apply as soon as possible before that date.

Further information may be obtained by writing the Executive Secretary, Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6, Ohio.

Committees Appointed to Meet With Welfare Officials

Dr. George R. Callender, Jr., of Charleston has been named chairman of a Joint Conference Committee which will meet at frequent intervals with Department of Welfare officials to make periodic evaluations and formulate modifications in the Medical Assistance for the Aged program which may be necessary or desirable.

The other members of the committee appointed by Dr. D. E. Greeneltch, president of the State Medical Association, are as follows:

Drs. Seigle W. Parks, Fairmont; W. Fred Richmond, Beckley; Charles M. Scott, Bluefield; Harry S. Weeks, Jr., Wheeling; and J. D. H. Wilson, Clarksburg.

The committee met with Mr. W. Bernard Smith, Commissioner of the Department of Welfare, on March 20.

District Committees

District review committees also have been set up throughout the state to meet with welfare officials on the local level. The primary function of the committees will be to process questionable vouchers and resolve differences which might arise. Those problems that cannot be settled locally will be referred to the committee named to meet with Mr. Smith.

The following is a list of physicians appointed to review committees throughout the state:

District 1 (Office in Wheeling): William Perilman, Wheeling; E. M. Clubb, Jr., Weirton; James E. Wise, Follansbee; T. O. Dickey, McMechen; and Kent M. Hornbrook, New Martinsville.

District 2 (Office in Fairmont): Frank W. Mallamo, Fairmont; J. C. Pickett and H. A. Rich, Morgantown; D. R. Davis, Kingwood; Lawrence B. Thrush, Clarksburg; and Hu C. Myers, Philippi.

District 3 (Office in Parkersburg): Charles H. Barnett, George E. McCarty and Francis H. Hughes, Jr., Parkersburg.

District 4 (Office in Martinsburg): Andrew Zepp and C. V. Townsend, Martinsburg; L. Mildred Williams, Charles Town; T. T. Huffman, Keyser; H. Luke Eye, Franklin; and Vernon L. Dyer, Petersburg.

District 5 (Office in Welch): Richard O. Gale, Welch; Russell A. Salton, Williamson; B. W. Steele, Mullens; Henry F. Warden, Jr., Bluefield; and George H. Guy, Union.

District 6 (Office in Huntington): Gerald J. Eder, Joseph Chambers and Ronald Crissey, Huntington; and C. Leonard Brown and J. Berrye Worsham, Jr., Point Pleasant.

District 7 (Office in Charleston): A. B. Curry Ellison, Charleston; J. M. Scott, Madison; and Earl Fisher, Gassaway.

District 8 (Office in Beckley): Everett B. Wray, Beckley; Everett H. Starcher, Logan; Joe N. Jarrett, Oak Hill; A. W. Holmes, Hinton; and Eugene McClung, Lewisburg.

District 9 (Office in Elkins): A. C. Thompson and C. L. Leonard, Elkins; S. M. Lilienfeld, Parsons; J. C. Huffman, Buckhannon; and R. R. Pittman, Marlinton.

Osteopathic Physicians Named

The West Virginia Society of Osteopathic Medicine will be represented on the state and local committees. Dr. Roy W. Eshenaur of Point Pleasant was named by the Society as a member of the Joint Conference Committee, and the following physicians were appointed as members of the district committees:

District 1—R. M. Crispell of New Cumberland; District 2—Frank A. Wallington of Bruceton Mills; District 3—R. J. Morey of Parkersburg; District 4—T. L.

Members of the Joint Conference Committee named to meet with Mr. W. Bernard Smith, Commissioner of the Department of Welfare. Left to right, Drs. Harry S. Weeks, Jr., of Wheeling, J. D. H. Wilson of Clarksburg, Charles M. Scott of Bluefield, Seigle W. Parks of Fairmont, W. Fred Richmond of Beckley, and George R. Callender, Jr., of Charleston, the chairman.

Sharpe of Martinsburg; District 5—O. J. Bailes of Princeton; District 6—Carlton G. Apgar of Huntington; District 7—W. R. Durham of Hurricane; District 8—Lloyd A. Dunbar of Beckley; and District 9—Walter S. Irvin of Weston.

Medical Meetings, 1962

The following is a partial list of national, state and district medical meetings scheduled for 1962:

Apr. 9-12—AAGP, Las Vegas, Nevada.
Apr. 12-14—W. Va. Chap. ACS, White Sulphur Springs.
Apr. 23-25—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
Apr. 28-29—Spring Meeting, W. Va. Soc. of Anesthesiologists, Morgantown.
May 25-27—W. Va. Chap. AAGP, Charleston.
June 6-8—W. Va. PH Association, Huntington.
June 21-25—ACCP, Morrison Hotel, Chicago.
June 24-28—AMA Annual Meeting, Chicago.
June 28-29—Seminar on "The Adolescent," WVU Medical Center, Morgantown.
Aug. 16-18—W. Va. Hospital Assn., White Sul. Springs.
Aug. 23-25—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 13-16—PG Institute, Martinsburg.
Sept. 20-21—W. Va. Heart Assn., Morgantown.
Oct. 22-23—American Cancer Soc., New York.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 24-25—ACCP, Ambassador Hotel, Los Angeles.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.

MLB Licenses 20 Physicians To Practice in State

The Medical Licensing Board has licensed 20 physicians as the result of the examination at the winter meeting held in Charleston, January 15-17, 1962. Four physicians were licensed by examination and sixteen by reciprocity.

The following physicians were licensed by examination to practice medicine in West Virginia:

Cserny, Andrew, Beckley
Holt, Marsh Hanford, Morgantown
Morrison, Clarence Fisher, Sutton
Velasquez, B. G., South Charleston

The following physicians were licensed by reciprocity:

Allen, Harold Young, Cumberland, Md.
Blake, Dora Alene, Oak Hill
Conrade, Noel Lawrence, Whitesville, Va.
Cook, Hugh H., Jr., Elkins
Countryman, Louis Kenneth, Morgantown

Dorset, Virgil Jackson, Belle
Duncan, Wallace Wayne, Bluefield
Halicke, Philip Volodar, Morgantown
Krivchenia, Gregory Bernard, Wheeling
Lenton, Charles Trewartha, Jr., Wheeling

McProuty, Joseph Richard, Morgantown
Nicholas, Edmund Mark, Beckley
Ruegsegger, Franklin McGill, Oakland, Md.
Rushmore, Charles Henry, Ravenswood
Selinger, Harold, Charleston
Severs, Ronald Gordon, Morgantown

The spring meeting of the Medical Licensing Board will be held at the New State Office Building in Charleston on April 30 for the purpose of licensing by reciprocity.

West Virginia Chapter of CARIH Organized in Charleston

A West Virginia Chapter of the Children's Asthma Research Institute and Hospital has been organized following a recent series of meetings in Charleston.

The purpose of the organization is to provide information and education concerning allergic diseases to the public which is accurate and factual, and in cooperation with the American Academy of Allergy, American College of Allergists and the Allergy Foundation of America. It is part of the Jewish National Home for Asthmatic Children in Denver, Colorado.

An open public meeting was held in the auditorium of the United Fuel Gas Company building in Charleston on February 16. Dr. Robert C. Bock, president of the Kanawha Medical Society, delivered an address of welcome.

The subject of the meeting was "How to Live With Your Allergies," and the speakers were Dr. Jose Quintero, Assistant Professor of Medicine and Chairman of the Division of Allergy at West Virginia University School of Medicine; Israel Friedman of Denver, Executive Director of CARIH; and Drs. Joseph T. Skaggs and Merle S. Scherr of Charleston.

PG Course in Cardiology

The American College of Physicians will sponsor a postgraduate course on "Fundamental and Applied Aspects of Cardiology" at the Wayne State University College of Medicine in Detroit, Michigan, May 14-16.

The registration fee will be $60 for ACP members and $80 for non-members. Dr. Richard J. Bing will serve as director of the three-day course. Further information may be obtained by writing the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania.

Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

The Integrity of the Manufacturer

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Since neither the physician nor the pharmacist are capable of the detailed chemical and clinical analysis necessary to determine these factors they must rely on the integrity and character of the manufacturer.—*Problems of Generic Prescribing:* D. F. Robinson, M. D., Director, Oklahoma University Student Health Service.

Dietetic Association Meeting in Fairmont

The spring meeting of the West Virginia Dietetic Association was held at the Hotel Fairmont in that city on March 30, in conjunction with the annual meeting of the West Virginia Restaurant Association.

The one-day meeting was primarily concerned with civil defense. Professor Homer Patrick of West Virginia University discussed "Radioactivity in Fallout" at the luncheon meeting, and the speaker at the banquiet was Mrs. Mary Rose Jones of West Virginia University, whose subject was "Civil Defense."

GP Meeting in Washington, May 5-6

A two-day scientific session, sponsored by the Maryland and District of Columbia Academies of General Practice, will be held at the Sheraton Park Hotel in Washington, D. C., May 5-6.

West Virginia physicians have been extended a cordial invitation to attend the meeting, and AAGP members will receive Category I credit. There will be no registration fee.

Information concerning the scientific program may be obtained by writing Mr. William J. Wiscott, Executive Secretary, Maryland Academy of General Practice, 3722 Greenmount Avenue, Baltimore 18, Maryland.

Thoracic Society Meeting in Miami Beach

The 57th annual meeting of the American Thoracic Society, medical section of the National Tuberculosis Association, will be held in Miami Beach, Florida, May 21-23. The Deauville and Carillon will be headquarters hotels.

The three-day meeting will feature lectures, symposia and round-table discussions. AAGP members will receive 19 hours Category II credit for attendance.

Further information may be obtained by writing the National Tuberculosis Association, 1790 Broadway, New York 19, New York.

State Physicians Among Contributors To 1962 'Current Therapy'

Three West Virginia physicians are among the contributors to the 14th annual edition of *Current Therapy*, edited by Dr. Howard F. Conn and published by the W. B. Saunders Company of Philadelphia.

Dr. Merle S. Scherr of Charleston is the author of an article on "Food Allergy in Children" which appears in the section entitled The Allergic Diseases.

"Injuries of the Genitourinary Tract" is the title of an article by Dr. John M. Bobbitt of Huntington, which is included in the section on The Urogenital Tract.

Dr. Rex B. Conn, Jr., Assistant Professor of Pathology at the West Virginia University School of Medicine, prepared tables on "Normal Laboratory Values of Clinical Importance" which appear on the inside front and back covers.

'Travel Meeting' of Ob.-Gyn. Society Held in Louisville, Ky.

The Annual Travel Meeting of the West Virginia Obstetrical and Gynecological Society was held at the University of Louisville School of Medicine in Louisville, Kentucky, March 12-13.

Eleven state physicians attended the meeting and an interesting program was arranged for their wives, including a tour of the city, a luncheon and a visit to the Hadley Pottery.

Dr. Douglas M. Haynes of the Louisville General Hospital conducted two operative clinics during the meeting. The following scientific program was presented by members of the hospital staff on Monday, March 12:

"Unusual Conditions of the Vulva and Introitus."—Harold W. Baker, M.D., Assistant Professor of Obstetrics and Gynecology.

"Cytologic Diagnosis of Cervical Malignancy."—William M. Christopherson, M.D., Professor of Pathology and Chairman of the Department.

"Carcinoma *in situ* in Pregnancy."—Harold J. Kosasky, M. D., Assistant Professor of Obstetrics and Gynecology.

"Experimental Placental Abruption."—Douglas M. Haynes, M. D., Professor of Obstetrics and Gynecology and Chairman of the Department.

On Tuesday, March 13, the speakers and their subjects were as follows:

"Venous Thrombectomy in Pregnancy."—J. Alex Haller, Jr., M. D., Assistant Professor of Surgery.

"Ovarian Carcinoma."—Laman A. Gray, Associate Professor of Obstetrics and Gynecology.

"Newer Anesthetic Agents in Obstetrics."—Donald Thomas, M. D., Assistant Professor of Anethesiology.

"The Placenta and Perinatal Research."—Frank Falkner, M. R. C. S., L. R. C. P., Associate Professor of Pediatrics and Acting Chairman of the Department.

At the conclusion of the scientific session on Tuesday, there were a number of case presentations by the resident staff of the Department of Obstetrics and Gynecology.

A banquet was held at the Brown Hotel on Monday evening. The speakers on the program and their wives were among the guests. During the brief business meeting, Drs. Douglas M. Haynes and Harold J. Kosasky were elected honorary members of the Society. Also discussed was the matter of where the travel meeting would be held in 1963.

The following persons attended the two-day meeting: Dr. and Mrs. Harry E. Beard and Dr. and Mrs. Gilbert A. Ratcliff of Huntington; Dr. and Mrs. Paul H. Cope of Wheeling; Dr. and Mrs. Frederick H. Dobbs and Dr. and Mrs. Robert E. Stone of Charleston; Dr. and Mrs. Warren D. Elliott of Beckley; Dr. and Mrs. A. J. Villani of Welch; and Drs. Herbert M. Beddow and Leo M. Seltzer of Charleston; George Gevas of Parkersburg; and E. D. Staats of Ripley.

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DOSAGE: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. For *children* daily dosages, in divided doses, range from 3 mg. (½ teaspoonful three times daily) for infants 3 to 6 months to 10 mg. (1 teaspoonful five times daily) for children 8 to 12 years. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. The recommended dosage schedules should not be exceeded.

NOTE: Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kasich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.: Weiss, J., and Simon, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.

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Research in the Service of Medicine

WVU Medical Center
—News—

• **Compiled from material furnished by Cletis Pride, Public Information Officer, West Virginia University Medical Center, Morgantown, W. Va.**

Dr. Werner A. Laqueur of Beckley has been appointed Clinical Assistant Professor of Pathology at the West Virginia University School of Medicine. The appointment was announced last month by University President Paul A. Miller.

Doctor Laqueur, who is director of laboratories at Beckley Memorial Hospital, will serve as a part-time member of the faculty at the School of Medicine while continuing his present duties.

A native of Schierke, Germany, he received his M. D. degree in 1936 from the University of Basel in Switzerland and had postgraduate training in Holland and Turkey.

Doctor Laqueur is certified by the American Board of Pathologists and he is a member of the Raleigh County Medical Society, West Virginia State Medical Association, American Medical Association and the International Academy of Pathology. He is immediate past president of the West Virginia Association of Pathologists.

Additional Appointments Announced

Dr. Max Plutzky, a native of Cuba who more recently lived and practiced in Miami, Florida, has joined the faculty of the School of Medicine as an instructor in psychiatry.

Doctor Plutzky received his M. D. degree in 1952 from the Havana University Medical School and served as intern and later as associate psychiatrist at the C. Garcia University Hospital in Havana, 1953-58. In 1960-61, he served as a psychiatrist at Mazorra State Hospital in Havana, while carrying on a private practice which began in 1955.

After coming to the United States, Doctor Plutzky served as psychiatrist at the VA Hospital in Coral Gables, Florida, prior to accepting the University appointment. He is a member of the Cuban College of Physicians.

Two physicians have been appointed to the clinical staff of the Department of Pathology. Dr. George Tolstoi of Uniontown, Pennsylvania, was named assistant professor and Dr. Nicholas Giarritta of Cumberland, Maryland, instructor.

Doctor Tolstoi was born in Washington, D. C., and he received his M. D. degree from George Washington University School of Medicine. He has served as pathologist at Uniontown Hospital since 1945. He is certified by the American Board of Pathology and is a member of the College of American Pathologists.

Doctor Giarritta, a native of Brooklyn, New York, was graduated from the University of Pennsylvania and received his M. D. degree from the University of Zurich in Switzerland. He served his internship at St. Clare's hospital in New York City and had residency training at the Hospital of St. Raphael in New Haven, Connecticut.

Research Grants

Dr. Barbara Jones, Assistant Professor of Pediatrics, has been awarded a $28,020 grant for a study of the mechanisms by which bilirubin is excreted by newborn babies. The research is sponsored by the National Institutes of Health.

The problem of bilirubin excretion is present to some extent in all newborns, Doctor Jones explained, but it is particularly important in cases of blood incompatibility—or "Rh babies." An investigation will be made of possible factors which may stimulate the activation of the enzyme system necessary for the excretion of bilirubin.

The University has been awarded $36,480 by the federal government to support a five-year research program on senility, mental retardation and mental illness. The National Institutes of Health has granted the money to Dr. Daniel T. Watts, Professor and Chairman of the Department of Pharmacology, for an investigation entitled "Catecholamines in the Aging Process and in Senility."

The study is directed toward gaining a better understanding of the role of norepinephrine and epinephrine on the function of the brain. Recent studies in Finland indicate there is a reduction in the amount of these materials in the brain from about the age of 43 until death.

The object of Doctor Watts's research will be to determine whether there is a relationship between the amounts of norepinephrine and epinephrine in the brain and senility and other mental diseases.

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Dosage: Adults, 1 Caplet (200 mg.) three or four times daily;
children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L.: M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association said that President Kennedy misstated the real issue when he renewed his request to Congress for legislation that would provide limited health care for the aged under social security.

"We believe the American people are entitled to know that the real issue is not medical care versus no medical care for the elderly," Dr. Leonard W. Larson, president of the AMA said.

"The real issue is: should wage-earners and employers be forced to pay a substantial increase in taxes to provide medical care for millions financially able to take care of themselves?

"No one supporting this proposal has yet presented any evidence that such radical legislation is needed.

"The medical profession is for the Kerr-Mills law to help the aged who need help. We are for voluntary enterprise, including health insurance and prepayment plans for the non-needy aged."

Patient's Freedom of Choice

Doctor Larson also disputed other statements on the issue which President Kennedy made in a new health message to Congress. Doctor Larson said that contrary to what Mr. Kennedy said, the Administration legislation (the King-Anderson bill) could interfere with the patient's freedom of choice of hospital and physician.

It would give the federal government "such broad power to control the practice of medicine in the nation's hospitals that the Secretary of Health, Education and Welfare would literally become the czar of American medicine," Doctor Larson said.

Doctor Larson also pointed out that it would not be a health insurance program as President Kennedy said. Instead, it was "political medicine," Doctor Larson said.

"As the Supreme Court of the United States has ruled, Social Security is strictly a tax program with current taxes used principally to provide benefits for those now retired," Doctor Larson said.

The President's Message to Congress

President Kennedy's new health message was a summation of various Administration proposals in the field with some additions. It included:

(1) Federal aid for construction of medical schools and scholarships for medical students.

(2) Expanded health research, including a new institute for child health and human development.

(3) More funds for the National Institute of Mental Research.

(4) Federal loans to help set up group practice clinics.

(5) Encouragement of states to provide medical services for migrant workers.

(6) Federal research and grants to help combat air pollution in cities.

(7) A three-year program of federal assistance to get American children vaccinated against polio, diphtheria, whooping cough and tetanus. The government would pay the cost of vaccines for all children under five, provided state and local communities set up inoculation programs.

(8) Establishment of a National Environmental Health Center "to provide a focal point for nationwide activities in the control of air pollution, water pollution, radiation hazards, and occupational hazards."

Investigation of Cold Remedies

A broad investigation of cold remedies to determine whether their advertising overstates their effectiveness has been started by the Federal Trade Commission.

As a start, the Commission sent questionnaires to 24 major manufacturers of cold remedies. Answers to the questionnaires are mandatory under the Federal Trade Commission Act. When and how many additional manufacturers will receive similar questionnaires has not yet been determined.

The answers to the questionnaires will enable the Commission to make a comprehensive review of problems throughout the entire field and will assist in evaluating scientific evidence claimed for the medicinal preparations.

The survey seeks information on all such preparations offered for the relief or treatment of congestion, irritation, inflammation, infection, allergy or other conditions involving any part of (1) head, including the accessory nasal sinuses, (2) throat, (3) bronchiti, (4) chest, or other portions of the respiratory system. The questionnaires also seek information on claims for the relief or treatment of any symptom or manifestation of these ailments.

The Commission's resolution stated that it had reason to believe that certain corporations in offering such products to the public "may have falsely advertised and misrepresented" their efficacy.

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Obituaries

AUBREY WEBSTER ARMENTROUT, M. D.

Dr. Aubrey Webster Armentrout, 60, of Martinsburg, died at a hospital in Baltimore on February 20 following a short illness.

Doctor Armentrout, who practiced his specialty of general surgery in Martinsburg for more than 25 years, was born at Linville, Virginia, on April 22, 1901, a son of the late Walter Scott and Myrtice Maddox Armentrout. He was graduated from the University of Kentucky and received his M. D. degree from Johns Hopkins University School of Medicine in 1926.

He interned at Jefferson Hospital in Roanoke, 1926-28, and served residencies at that institution and at the University of Virginia Hospital in Charlottesville, 1928-31. He received a Master of Science Degree in surgery from the University of Virginia in 1931.

He was licensed to practice medicine in West Virginia in 1933 and located at Martinsburg. He served with the Medical Corps of the United States Army during World War II, and was separated from service in 1946 with the rank of Lieutenant Colonel.

Doctor Armentrout was a member of the American College of Surgeons, the Eastern Panhandle Medical Society, West Virginia State Medical Association and American Medical Association. He served a term as president of his local society.

Besides his widow, he is survived by a son, Walter S. Armentrout, a student at Brown University; and a brother, Lyle Armentrout of Harrisonburg, Virginia.

* * * *

JESSE FRANK WILLIAMS, JR., M. D.

Dr. Jesse Frank Williams, Jr., 53, who practiced medicine in Clarksburg since 1938, died at his home in that city on February 19.

Doctor Williams was born in Baltimore, Maryland, on February 14, 1909, a son of Mrs. Anna Morrison Williams and the late Dr. Jesse Frank Williams. He was graduated from West Virginia Wesleyan College and received his M. D. degree from the University of Maryland School of Medicine in 1935.

He interned and served a residency in surgery at the Maryland General Hospital in Baltimore, 1935-37. He located in Clarksburg the following year.

Doctor Williams served as Coroner of Harrison County during the past two years and he was a member of the Harrison County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his mother, he is survived by his wife, Marguerite Singleton Williams; a daughter, Mrs. Edward Twohy of Richmond, Virginia; a son, Jesse Frank Williams, III, a pre-medical student at West Virginia University; a sister, Mrs. David Kehoe of Arbutus Park; and a brother, John W. Williams of Tucson, Arizona.

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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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County Societies

CABELL

Dr. James A. Heckman presided at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on March 8. The meeting was attended by 42 members.

Dr. John M. Bobbitt, chairman of the Committee on Public Service and Education, discussed advertising copy which will appear in local newspapers in conjunction with the following statement of policy.

"The Cabell County Medical Society strongly favors a good program for medical aid to the aged. This Society endorses the Kerr-Mills bill passed by Congress in 1960 and now in effect in 38 states, including West Virginia. We support this program because it was designed to help those senior citizens who need help, and because the Federal matching funds come from general tax revenues. In the future, this Society will continue to press for improvement of the Kerr-Mills program in West Virginia.

"The Cabell County Medical Society hereby expresses its opposition to the King-Anderson bill, now under study in Congress, because this legislation would be financed by Social Security taxation. We sincerely believe that financing by Social Security taxation would place a grossly unfair burden on the little taxpayer. This Society also believes that the excellence of American health care would be endangered by the provisions in the King-Anderson bill which provide our government the mechanism whereby it could assume direct control over health care."

Drs. T. W. Moore and J. J. Brandabur were elected to honorary life membership in the Society.—W. L. Neal, M. D., Secretary.

* * * *

MERCER

Dr. Carlyle Crenshaw was the guest speaker at the regular monthly meeting of the Mercer County Medical Society which was held at the West Virginian Hotel in Bluefield on February 19.

Doctor Crenshaw presented an interesting paper on the "Anemias of Pregnancies." He discussed iron deficiency anemia, megaloblastic anemia and sickle cell anemias. He emphasized that there is no so-called physiologic anemia of pregnancy.

Dr. Joe McCary, the president, presided at the business meeting which followed the scientific program. The Society voted to place public service advertisements in the Princeton and Bluefield newspapers.

The Society also went on record as approving the National Blue Shield Senior Citizen program which would provide pre-paid medical and surgical care for persons over 65 years of age.—John J. Mahood, M. D., Secretary.

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C. D. Hershey, M. D.
E. C. Voss, M. D.

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A. J. Berlow, M. D.

Ophthalmology:
Robert A. Dye, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Barbara Karrer, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
JoAnn Hastings
Roentgenology:
Evelyn Forester, R. T.

Business Administration:
John H. Clark, Manager
Lester L. Cline, Ass't. Bus. Mgr.

MONONGALIA

Dr. William A. Welton was the guest speaker at the regular monthly meeting of the Monongalia County Medical Society which was held at the Hotel Morgan in Morgantown on February 13.

Doctor Welton, who is instructor and chairman of the Division of Dermatology at the West Virginia University School of Medicine, presented an interesting paper on "Dermatological Lesions." He used slides to illustrate his talk.

Mr. John Pompelli of Chicago, Field Representative of the American Medical Association, gave an interesting talk on the King-Anderson bill and related topics.

He emphasized the importance of physicians and their wives informing the public of the true facts concerning H. R. 4222, which would place the medical aid for the aged program under the Social Security system. A lengthy question and answer period followed.

Mr. Pompelli stated that the AMA has a large supply of literature which is available to local physicians. —George A. Curry, M. D., Secretary.

* * * *

OHIO

Dr. William J. Steger presided at the regular monthly meeting of the Ohio County Medical Society which was held on February 27.

During the business meeting, a report of the Public Service Committee was presented which outlined the campaign to defeat the King-Anderson Bill. The Society unanimously approved the Committee's aggressive campaign to inform the public that this proposed legislation would not be good for the public or medicine.

Drs. H. B. Copeland and L. B. Farri were elected to honorary life membership in the Society, and Drs. A. J. Berlow and E. C. Voss, Jr. were elected to membership.—William H. Hagedorn, Jr., Executive Secretary.

Army Residency Training Program

Captain J. Byron Munger, Army Medical Personnel Councillor for Western Pennsylvania and West Virginia, has announced that vacancies exist in the Army's Residency Training Program in the following specialties: anesthesiology, psychiatry, urology, radiology, pediatrics and pathology.

Medical Corps officers of the regular Army and reserve components and civilian physicians, including interns, are eligible for the program. Although acceptance for a regular Army commission is not a requirement for appointment as a resident, the purpose of the program is to provide the Army with sufficient career personnel having the required specialty training.

Additional information concerning the program may be obtained by writing Captain J. Byron Munger, Personnel Councillor, Second United States Army, Room 205-A, Old Post Office Building, Pittsburgh 19, Pennsylvania.

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in the "frantic forties"—For many patients in their "frantic forties," the pace never slackens—may even accelerate—while tensions multiply and physical resources dwindle. Out of this seedbed of stresses and anxieties grow much of the alcoholism, psychosomatic illness, and sympathetic overactivity of the middle years.

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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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INDICATIONS: VISTARIL is effective in premenstrual tension, the menopausal syndrome, tension headaches, alcoholic agitation, dentistry, and as an adjunct to psychotherapy. It is recommended for the management of anxiety associated with organic disturbances, such as digestive disorders, asthma, and dermatoses. Pediatric behavior problems and the emotional illnesses of senility are also effectively treated with VISTARIL.

ADMINISTRATION AND DOSAGE: Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: I.M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

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Second Vice President: Mrs. L. Dale Simmons, Clarksburg
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Corresponding Secretary: Mrs. Fred Moomau, Petersburg
Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

REGIONAL CONFERENCE IN CLARKSBURG

The annual Regional Conference and Executive Board meeting of the Woman's Auxiliary to the West Virginia State Medical Association will be held on Tuesday and Wednesday, April 10-11, at the Stonewall Jackson Hotel in Clarksburg. Luncheon will be served on Tuesday at 12:30 P. M., and the Executive Board meeting will begin promptly at 1:30.

On Tuesday evening all Auxiliary members are invited to an informal social hour as guests of Mrs. L. Dale Simmons, eastern regional director, in the Dixie Room of the hotel. A dutch treat dinner will follow.

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A continental breakfast will be served by the members of the Harrison County Auxiliary at 9:30 A. M. on Wednesday, and the conference will begin promptly at 10 o'clock. Luncheon will be served at the hotel at 12:30 P. M. and all members attending may leave as soon afterward as they wish.

The members of the Woman's Auxiliary to the Harrison County Medical Society sincerely hope that all members of the Executive Board, and component officers and committee chairmen of the local auxiliaries, as well as the incoming officers and committee chairmen, will plan to attend this conference.

* * * *

HARRISON

A Doctor's Day dinner-dance was held March 1 at 7:00 P. M. at the Wonder Bar in Clarksburg by the Woman's Auxiliary to the Harrison County Medical Society.

Mrs. Donald H. Lough, chairman of the social committee, was in charge of arrangements. She and her Committee members planned a very successful and enjoyable affair.

Seventeen neighborhood coffees have already been held under the plan of "Operation Coffee Cup." The Ronald Reagan record in which he speaks out against socialized medicine has been played. The Auxiliary has planned many more of these functions.—Mrs. J. Keith Pickens, Press and Publicity.

KANAWHA

Samples from the absorbing interests of medical families, arranged by the Woman's Auxiliary to the Kanawha Medical Society, were placed on display at the Kanawha Hotel in Charleston on February 13. Mrs. E. V. Jordan served as chairman of the exhibit.

Included in the exhibit were oil paintings by Dr. W. Paul Elkin, including caricatures of physicians at work; a collection of antiques owned by Dr. and Mrs. V. T. Churchman, including saddle bags from the pre-sulfanilamide days; a charcoal painting by Mrs. John M. Hartman; and a collection of the Old World and the New arranged from keepsakes and hobbies of Dr. Mike Kovacevich.

Other exhibits included those placed on display by Dr. Paul C. Soulsby, Mrs. O. M. Harper, Mrs. A. M. Earle, Mrs. Daniel N. Barber, Mrs. John W. Hash, Mrs. Spencer L. Bivens, Mrs. E. W. Squire, Mrs. J. Preston Lilly, Mrs. Lula V. Haley, Mrs. Charles H. Engelfried, Mrs. Merle S. Scherr and Dr. William R. Rice.—Mrs. Paul Francke, Jr., Publicity Chairman.

* * * *

MARION

Miss Martha Sacci was the guest speaker at a meeting of the Woman's Auxiliary to the Marion County Medical Society which was held at the home of Dr. and Mrs. F. W. Mallamo in Fairmont on February 27.

Miss Sacci, who is president of the Marion County Women's Civil Defense Council and Director of Nurses

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at Fairmont General Hospital, said that "the defense of the country is important and must become our way of life . . . the world is changing and we must change with it."

The speaker said that apathy and lack of interest are the major issues to be confronted. "Not only war, but man-made disasters are to be considered," she said, "and civilian and military defense must go hand in hand."

Mrs. J. J. Jenkins, Jr., the president, presided at the business meeting. Plans for "Doctor's Day" were discussed and Mrs. Rupert W. Powell was appointed to serve as chairman of the annual observance.

* * * *

McDOWELL

Miss Alice Scott Leslie of Charleston was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the McDowell County Medical Society which was held at the First Presbyterian Church in Welch on February 14.

Miss Leslie, who is executive secretary of the West Virginia Association for Mental Health, stressed the need for county mental health organizations and emphasized the importance of diagnosis and treatment of emotionally ill and retarded children.

Another honor guest at the meeting was Mrs. John W. Hash of Charleston, first vice president of the State Auxiliary, who accompanied Miss Leslie to Welch. The guests were entertained at a luncheon at

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E. E. MYERS, M. D.

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Internal Medicine:
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J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Anatomic Pathology:
S. D. WU, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

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LEOPOLDO I. PENA, M. D.
TADAO NAGASHIMA, M. D.

THE MYERS CLINIC

Philippi, West Virginia

the home of Dr. and Mrs. F. L. Johnston preceding the meeting.

During the business meeting plans were made for the annual observance of "Doctor's Day" and the Auxiliary turned over $417 to the Crippled Children's Society. This is one of the Auxiliary's most important projects—raising money for the Society and providing sandwiches, cookies and milk for approximately 80 children each month.—Mrs. F. L. Johnston, Secretary and Publicity Chairman.

* * * *

MERCER

Dr. William F. Hiller, Jr., was the speaker at the February luncheon meeting of the Woman's Auxiliary to the Mercer County Medical Society which was held at the Bluefield Country Club.

Doctor Hillier gave an interesting talk on "Is Federal Medicine the Answer?" He discussed government medicine and the work of different agencies, pointing out that socialized medicine is not working satisfactorily in countries that have adopted the program.

Doctor Hillier stated that the cost of the government plan in England is far exceeding the original estimates. He said that physicians also are unable to practice good medicine because of the large number of patients they must see daily.

Mrs. Hillier, the president, presided at the business meeting and Mrs. J. E. Blades, Jr., announced plans for "Doctor's Day" on March 29 which will feature a dinner and style show.

* * * *

OHIO

Dr. Joseph L. Curry was the speaker at the regular monthly meeting of the Woman's Auxiliary to the Ohio County Medical Society which was held at the Elks Club in Wheeling on February 27.

Doctor Curry, who is chairman of the public service committees of the local Society and the West Virginia State Medical Association, discussed national legislation. He stressed the importance of defeating the King-Anderson bill which would place the medical aid for the aged program under the Social Security program.

Mrs. George M. Kellas, the president, presided at the luncheon meeting which was attended by more than 40 persons.

* * * *

PARKERSBURG ACADEMY

Mrs. Lawrence R. Leeson was elected president of the Woman's Auxiliary to the Parkersburg Academy of Medicine at a meeting which was held at the home of Dr. and Mrs. S. William Goff on March 13. Other new officers elected for the coming year are as follows:

Mrs. Charles W. Thacker, president elect; Mrs. Rex Dauphin, first vice president; Mrs. Robert C. Cowen, Jr., second vice president; Mrs. Richard J. Lilly, corresponding secretary; Mrs. George W. West, recording secretary; and Mrs. Watson F. Rogers, treasurer.

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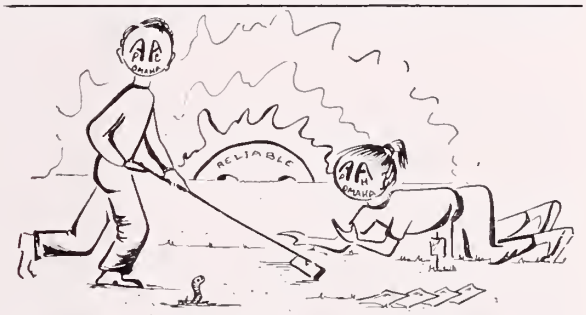

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Mrs. George Gevas presided at the business session, and Mrs. Charles L. Goodhand presented a report as chairman of the Legislative Committee.

Mrs. Gevas announced that the Annual Doctor's Day observance would be held on March 29, and that the Dogwood Ball would be held on May 5. Proceeds from the dance will be distributed to the nurses recreational funds at the local hospitals and to the American Medical Education Foundation.

Hostesses for the meeting were Mrs. S. William Goff, chairman; and Mesdames O. H. Brundage, Charles F. Whitaker, Jr., Robert S. Widmeyer, Paul L. McCuskey and Dwight P. Cruikshank.—Mrs. Ira Connolly, Jr., Press and Publicity.

Our Lightest Word

I wonder if we realise how some patients regard our lightest word.

The old lady had been ill for many years and I always went to see her on Saturday. Last week she was, if anything, a little better than usual, and I was surprised to be told on Tuesday that she had died. I hastened round to offer my sympathy and said that I had hoped she would live for quite a while yet. "But, doctor, you told us on Saturday she was going to die."

"I did? How?"

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New Saunders Books

W. B. Saunders Company features the following recent books in their full-page advertisement appearing on page vii in this issue:

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Aerospace Medical Assn. Meeting

The 33rd Annual Meeting of the Aerospace Medical Association will be held at the Chalfonte-Haddon Hall in Atlantic City, New Jersey, April 9-12.

James E. Webb, Administrator of the National Aeronautics and Space Administration, will present the annual Louis H. Bauer Lecture.

Further information concerning the meeting may be obtained by writing Dr. William J. Kennard, Executive Vice President, Aerospace Medical Association, Washington National Airport, Washington 1, D. C.

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SITUATION WANTED—Orthopedic surgeon desires to relocate in a partnership or solo practice, preferably in a community of 50,000 or larger. Board eligible and military obligation fulfilled. For particulars write TJE, The West Virginia Medical Journal, Box 1031, Charleston 24, W. Va.

WANTED—General practitioner, between the ages of 40 and 50. Salary dependent on personal qualifications and ranges from $6,995 to $12,210 per year. Write J. F. Heavey, Chief, Personnel Division, VA Hospital, University Drive, Pittsburgh 40, Pa.

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WANTED—General practitioner and internist. Twenty man general practice and specialty group in Taconite area of northern Minnesota. Heavy industrial. New hospital facility completed in 1960. Unusually liberal partnership agreement. Starting salary up to $1200. Excellent hunting, fishing, skiing area. Write A. G. Farley, East Range Clinic, Virginia, Minnesota.

AVAILABLE—Position of Physician to act as admitting physician, active 196-bed GM&S hospital. Salary dependent on qualifications; citizen. Many fringe benefits. Write Manager, Veterans Administration Hospital, Beckley, West Virginia.

WANTED—House physician for GP duty in general hospital (125 beds). No exchange students. Foreign graduates with immigrant visa and fluent English, $500 monthly and single maintenance. Write Kenneth N. Byrne, M. D., Superintendent, Emergency Hospital, Welch, West Virginia

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WANTED—Young physician for training and career in industrial medicine. A large chemical company outstanding in its field. Please send as soon as possible resume with letter, giving name, address, phone number, age, training, medical education and licensure. plus a recent photograph. Address, P. O. Box 993, Charleston, West Virginia.

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Health Insurance Policies Available to the Aged

The number of guaranteed-for-life health insurance policies and plans available to persons in or near retirement is increasing at a rapid rate, the Health Insurance Institute reported recently. The Institute said the second edition of a booklet it has published shows the extent of recent growth in older-age health cost coverage. The booklet lists details, including premiums and benefits, of health insurance programs available to the aged from insurance companies.

The first edition of the booklet was published in July, 1961, and contained 126 guaranteed-for-life plans and policies available to the aged. The policies were provided by 66 different companies. Developments in this area were so rapid, the Institute said, that the booklet soon was outdated and a second edition, based on material compiled as of January 1962, has been published.

The new edition shows that in the space of six months there has been a 25 per cent increase in the number of policies offered in this field, and a similar increase in the number of companies active in this area of insurance. As of the beginning of the year, 81 insurance companies were providing a total of 157 policies and plans that are guaranteed for life.

The Institute pointed out that developments are coming so swiftly in this field that although it sought to make the new booklet as complete in its listings as possible, it can not be considered an all-inclusive listing.

The Institute said many of the policies listed in the booklet are available to anyone 65 or older regardless of physical condition. Some of the policies accept new applicants up to age 80 or older, and some group-type plans enroll people 100 or older. Some of the policies, which become paid up for life at age 65, are designed for persons under 65.

The Institute said all of the policies have a lifetime guarantee, which means the insured person paying his premium retains his coverage regardless of how his health may change. The HII added that protection for persons enrolled in the group-type plans cannot be terminated by the insurance company for any individual policyholder—only for residents of an entire state as a group.

The booklet includes programs developed for all types of medical expenses—hospital, surgical, physicians' visits, and major hospital and medical expenses.

Tomorrow's Miracle Drug

Whether it be in electronics or in drugs, modern research requires enormous sums of money spent with considerable boldness; there are more research efforts that fail than succeed. Good public policy is that which most encourages men to search for new things from which all society will profit. Before we wreck the patent system, we might ask whether it is better that somebody have a "monopoly" on tomorrow's miracle drug than that the miracle lie undiscovered.—Wall Street Journal.

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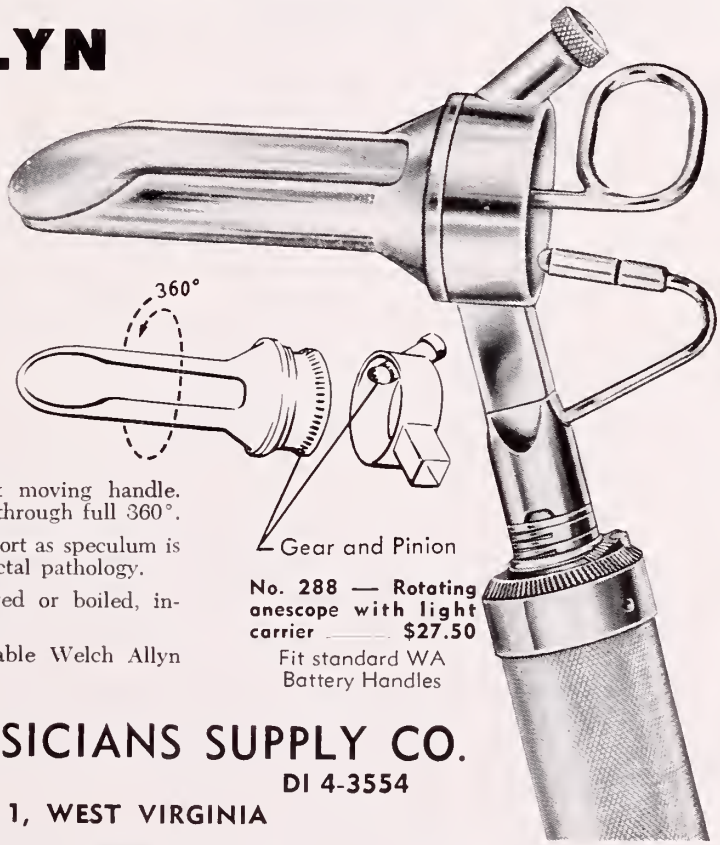

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'He Climbed Into a Boat And Sailed Away'

"They dragged the British medical horse to the water, but instead of drinking, he climbed into a boat and sailed away."

This epigram sums the effect on medical practice of the British National Health Service in another letter to a CMA staff member from an English physician. His previous penetrative essays on this subject have given us much insight into the workings of socialized medicine in Britain. His newest letter continues this. In part, he writes:

"Is it not an interesting paradox that those nations which are most fundamentally opposed to collectivized political regimes are most drawn to collectivized medical services?

"It must be made plain to the American people that the hallowed British National Health Service is popular with egalitarian politicians and the greedier members of the public, but has led to a critical loss of doctors.

"Our hospitals are staffed preponderantly by African and Asian doctors who will leave Britain in a flood as soon as your Income Tax raises their salaries in Africa and India. Our Service will then break down overnight.

"Whether they admit it or not, it has come as a rude shock to the politicians that their triumph of 1948 has been shortlived: they dragged the British medical horse to the water, but instead of drinking, he climbed into a boat and sailed away.

"Able men no longer enter Medicine in this country."—Newsletter, California Medical Assn.

Mail-Order Prescriptions

The mail-order filling of prescriptions is said to be a mushrooming business. Descriptions of the premises, equipment, and general lack of professional atmosphere in some of the places where mail-order prescriptions are filled have shown anything but the appearance of a well-run drug business. Obviously some of these concerns are conducted only for the profits and just as obviously have no regard for the welfare of the patient.

Even if a drugstore dedicated to mail-order pharmacy were clean, well stocked and gave the appearance of honesty, such a way of obtaining drugs would not be in the best interest of either the patient or the physician. Delay, uncertainty of getting what the prescription calls for, difficulty in altering treatment as required in a given case, lack of patient-doctor-pharmacist relationship, difficulty for the doctor to check on the faraway druggist, lack of direct communication between doctor and druggist, and many other difficulties and dangers combine to make mail-order prescription business hazardous, clumsy, and inconvenient. We should do all we can, as doctors, to discourage it.—Nebraska State Medical Journal.

What a good thing Adam had—when he said a good thing, he knew nobody had said it before.—Mark Twain.

MAY
1962

Vol. 58 No. 5

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia Phone Dickens 4-4625.

Member 1962

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The West Virginia Medical Journal

May, 1962 Vol. 58, No. 5

The Intersex Problem*†

T. S. Danowski, M. D., D. C. Borecky, M. D., F. M. Mateer, M. D., W. R. Balash, M. D., J. V. Bonessi, M. D., and A. C. Heineman, Jr., M. D.

The normal human infant, child, or adult has a total number of 46 chromosomes in all cells of the body including those which are developing into spermatozoa or ova; the total is referred to as the diploid number. Forty-four of the chromosomes are classified as autosomes while the remaining two are the sex chromosomes. The latter are large and designated as XX in the female; in the male there is one X chromosome and one smaller Y chromosome. In the normal mature sperm or ovum the total chromosome number is reduced to 23 (the haploid number). These consist of 22 autosomes and an X or a Y sex chromosome in each sperm and 22 autosomes and an X sex chromosome in each ovum. With fertilization the diploid number is restored to 46 with an XX or XY sex chromosomal pattern, depending on whether the sperm carried an X or a Y.

The so-called genetic sex of an individual can be roughly estimated from a determination of the nuclear chromatin. Thus, when two or more X chromosomes are present a dark stained mass of nuclear chromatin (probably derived from the heterochromatic segment of an X chromosome) first described by Barr and Bertram[1] in the nervous system and other tissues of cats can be detected in a variable proportion of cells of the buccal mucosa, vaginal mucosa, granulation tissue at the edge of the nucleus and in circulating polymorphonuclear leukocytes. If this is present the nuclear chromatin is designated as positive; if it is absent it is called negative. Because of the possible emotional impact on patients with disorders of nuclear chromatin the phrase "sex chromatin" should be assiduously avoided.

For more precise definition the chromosomal pattern or karyotype must be constructed. Figure 1 shows the karyotypes of a human male and a female in good health, as arranged by Robinson.[2]

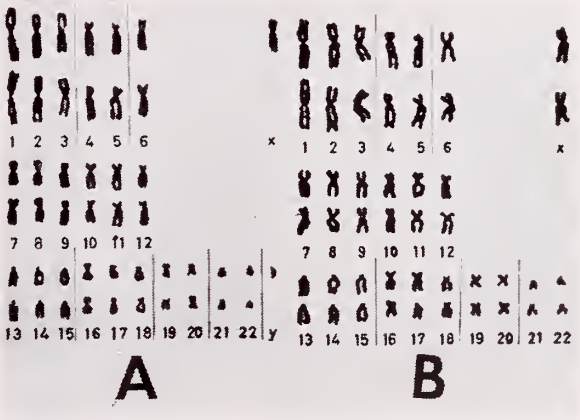

Figure 1. Karyotypes of normal human, male (A) and female (B), showing the 46 chromosomes and the XY and XX patterns. (Reproduced with permission of Dr. Arthur Robinson, Am. J. Dis. Child., 101:379, 1961; and the editor and publisher).

The Authors

- T. S. Danowski, M. D., Professor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania.
- D. C. Borecky, M. D., F. M. Mateer, M. D., W. R. Balash, M. D., J. V. Bonessi, M. D., and A. C. Heineman, Jr., M. D., Department of Medicine, University of Pittsburgh School of Medicine. Drs. Borecky, Balash and Bonessi served as trainees under a grant from the USPHS.

*Presented by Doctor Danowski before the Fifth Annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, October 21, 1960.

†From the Section of Endocrinology and Metabolism of the University of Pittsburgh School of Medicine and the Medical Center and Shadyside Hospitals.

Aided by grants from the American Cancer Society, the Department of Health, Education and Welfare, and the John A. Hartford Foundation, Inc.

Submitted to the Publication Committee, December 23, 1961.

TABLE 1

SUMMARY OF RECOGNIZED INTERSEXES AND OTHER SOMATOSEXUAL AMBIGUITIES

	Nuclear Chromatin	Total No. of Chromosomes	Sex Chromosomes	Gonads	Internal Genitalia	External Genitalia	Body Build	Urinary			Gametes
								Estrogens	17-Ketosteroids	Gonadotropins	
A. Pseudohermaphroditism Female	+	46	XX	Ovaries	Female	Pseudo male	Suppressed female; masculinization	↑ [a] ±	↑ [b]	↓	Suppressed follicle development
1. Adrenogenital syndrome											
2. Testosterone, progesterone, etc. treatment											
3. With gross G-I, G-U abnormalities											
4. Unexplained											
Male (testicular feminization)	— (rarely +)	46	XY	Testes	Male	Pseudo female	Female		Normal	Normal	Suppressed spermatogenesis
1. Spontaneous											
2. Massive estrogen treatment of mother											
B. Chromosomal intersexes											
1. Turner's syndrome (ovarian disgenesis)											
Female Turner's syndrome	—	45	XO or XX; ? mosaic	Vestigial ovaries	Female	Immature female	Immature female	↓	Normal or ↓	↑	Immature or absent
Male Turner's syndrome	—	45	XO	Hypofunction of testes	Male and occasionally rudimentary female	Male	Male		Normal or ↓		Defective spermatogenesis and often Leydig cell function
2. Klinefelter's syndrome (seminiferous tubule sclerosis)	+	46, 47, or 48	XXY, XY, XXXY, XXY/XY, XXYY, etc.	Testes	Male	Male	Male or eunuchoid	Normal or ↑	Normal or ↓	↑	Seminiferous tubule sclerosis
C. True hermaphroditism	+ or —	46 (?45)	Concordant, ? mosaic, or XX with male phenotype	Ovaries and testes	Variable	Variable	Male (less often female)		Normal	?	Suppressed
D. Somatosexual ambiguity with dysgerminoma, teratoma, etc., of gonads											
E. Absence of gonads, male or female[c]											
F. Triplo X or superfemale with somatic and sexual anomalies	+	47		Ovaries							

[a] ↑ = increased; ↓ = decreased; G-I = gastrointestinal; G-U = genito-urinary.
[b] In spontaneous adrenogenital syndrome only.
[c] 6 cases cited by Gross & Meeker, Pediatrics, 16:303, 1955.

Karyotypes permit the identification of deviations from normal. Abnormalities identified to date include abnormal total chromosomal number of 69, i. e., three times the usual haploid number, and lesser increases and decreases from the usual complement of 46, i. e., 45, 47, 48, et cetera. Mosaics such as XXY/XY also may be present.

Identification of genetic patterns is of recent origin and some of the conclusions may have to be modified. It is already clear, however, that in mongolism the autosome number is frequently increased by one,[3a-d] that in anencephaly there is a preponderance of genetic females,[4a, b] that abnormalities of chromosomes occur in certain forms of leukemia,[4c] and that the identification of intersexes has been greatly facilitated.

I. Classification of Intersexes

At present three general classes of intersexes are recognized: (a) pseudohermaphroditism of the female and male types, (b) chromosomal intersexes, i. e., the Turner or Bonnevie-Ullrich-Turner syndrome or ovarian dysgenesis or agenesis and the Klinefelter syndrome in which seminiferous tubule sclerosis is a frequent feature and (c) true hermaphroditism (Table 1). In addition, ill defined somatosexual ambiguities or disorders which do not fall into any of these categories may occur with an ovarian neoplasm such as a teratoma or dysgerminoma, with the triple-X or superfemale nuclear chromatin pattern, and with total absence of gonads and genitals.

A. *Pseudohermaphroditism.*—In pseudohermaphroditism of the female type the patient is a gonadal and genetic female, i. e., the nuclear chromatin is positive, the total chromosome count is 46 and two X chromosomes are present. The external genitalia and soma, however, acquire male characteristics usually as a consequence of a spontaneous or iatrogenic excess of masculinizing steroids. Unexplained instances of female pseudohermaphroditism also may occur with or without gross abnormalities of the lower gastrointestinal tract and urinary apparatus such as cloaca formation, imperforate anus and kidney anomalies.[5a-k]

On the other hand, in male pseudohermaphroditism the patient is a genetic and gonadal male, i. e., the nuclear chromatin is negative, the sex chromosomal pattern is XY, and testes are present in the abdomen or externally, but the body build and external genitalia have female features. This is testicular feminization.[6a-j] Its origins are obscure but an example which followed massive antenatal estrogen therapy has been reported.[6k]

B. *Ovarian Agenesis or Dysgenesis (Turner's Syndrome.)*—In the so-called chromosomal intersexes the nuclear chromatin and sex chromosomes are frequently abnormal. In ovarian dysgenesis the pattern often is XO but may be XX in approximately one in five cases. In these patients the body build and genitalia generally are those of an immature female (Table 2), with other somatic anomalies such as webbing, cubitus valgus and coarctation of the aorta, which can be a feature of the Turner and the Bonnevie-Ullrich-Turner syndrome.[7a-e]

External males with these associated somatic abnormalities have been recognized as so-called male Turner's syndrome with testes.[8a-s] The nuclear chromatin and the sex chromosomes have been negative and XO in the few male patients characterized to date.[8s] Generally spermatogenesis has been inadequate in this group.

C. *Klinefelter's Syndrome (Seminiferous Tubular Sclerosis).*—In Klinefelter's syndrome the body build, external genitalia and gonads are grossly male but the patient appears eunuchoid, gynecomastia often develops, spermatogenesis is decreased or absent, the seminiferous tubules become sclerosed (Table 3), and the sex chromosomes are frequently abnormal with an XXY (chromatin positive, total count 47), XXY/XY mosaic pattern (chromosome positive or negative and total counts of 47 or 46), or other variants such as XXXY (Table 1). The pattern is a normal XY in the remaining third, i. e., chromatin negative with a total count of 46.[9a-h]

D. *True Hermaphroditism.*—In the true hermaphrodites, recognizable though rudimentary and apparently only partially functional male and female gonadal tissues are present. Any abnormality of the external genitalia should raise the possibility, though admittedly this is not very likely, of true hermaphroditism. The suspicion should be greatly heightened in any individual who gives a history of abdominal pain at monthly intervals, especially if intermittent bleeding occurs either via a penile urethra or a rudimentary vagina.

Though the essential feature of true hermaphroditism is the presence both of ovarian and testicular tissue, this does not mean that the gonads of each sex are necessarily producing normal and fully developed gametocytes. Fertility of such gametes appears unlikely and in addition gross anatomic abnormalities in the sex organs make reproduction impossible. Thus, even though approximately 100 examples of hermaphroditismus verus have been reported, pregnancy or impregnation had not occurred in any.

TABLE 2

CHROMATIN NEGATIVE EXTERNAL FEMALES WITH TURNER'S SYNDROME

Patient	Age	Hgt.	Menses	Cubitus valgus	Neck webbing	Female breasts	Hair			Genitalia on Physical Examination						Gonadotropins (m.u.u.)	17-Ketosteroids (mg./d.)	11-Oxysteroids (mg./d.)
							Body	Pubic	Axillary	Ovaries	Uterus	L. majora	L. minora	Vagina	Clitoris			
J. F.	20	5'2"	0	+++	+	+	+	+	0	0	↓	↓	↓	Norm.	Norm.	0	1.6	3.2
C. C.	17	5'1"	0	+++	+	0	+	0	0	0	↓	↓	↓	Norm.	↓	0	1.6	1.6
P. B.	17	4'4"	0	+++	+	0	+	+	0	0	↓	↓	↓		↓		2.6	

0 = none, + = slight, ++ = moderate, +++ = marked, ↓ = decreased, Norm. = normal, m.u.u. = mouse uterine units
11-Oxysteroids as Porter-Silber chromogens

TABLE 3

NUCLEAR CHROMATIN POSITIVE KLINEFELTER'S SYNDROME

Patient	Age	Height (cm.)	Span (cm.)	Pubis-Floor (cm.)	Testes (cm.)	Penis (cm.)	Gynecomastia	Hair						Urine			Testis Biopsy
								Scalp	Beard	Trunk	Extremities	Pubic	Axillary	Gonadotropins (m.u.u.)	17-Ketosteroids (mg./d.)	11 Oxysteroids (mg./d.)	
L. B.	41	175	175	95	1.0	9.0	+	+++	+	+	+	+	0				
E. K.	17	178	181	92	1.6	9.5	+	++	0	+	+	+++F	+	106	14		Seminiferous tubule sclerosis
B. E.	16				1.5	N	+	+++	0	+		+++		6.6	1		Seminiferous tubule sclerosis
R. Hr.	16	188	197	99	1.8	6.5	+	+++	+	↓	+	+++F	+	106, 53	15		Seminiferous tubule sclerosis
J. R.	38				↓	↓	+		+	+	+++	+	+				Seminiferous tubule sclerosis
R. H.	20	168			1.5	↓	+	++		++		+++	++		30		Seminiferous tubule sclerosis
J. Mc.	18	182	185	97	1.5	7.5	0	+++	+	Fine	+++	+++F	+	0	21	3.7	Seminiferous tubule sclerosis

↓ = decreased, N = normal, 0 = none, + = slight, ++ = moderate, +++ = marked, F = female type, m.u.u. = mouse uterine units

Of the verified cases of true hermaphroditism with adequate information available, approximately half have been characterized by discrete collections of testicular tissue and of ovarian tissue. In the remaining cases ovotestes were present either alone or with an additional separate ovary, separate testis, or unidentified gonad, in that order of frequency.[10] In those with separate ovarian and testicular tissue the ovaries generally have been located in the abdomen and the testes in the scrotum. Inguinal or scrotal ovaries, however, and inguinal or scrotal testes occasionally have been encountered. The ovotestes, when present, have been accompanied more often than not (ratio of about 2 : 1) by another discrete gonad. Four times out of five this was an ovary.

Only a few observations on nuclear chromatin and sex chromosomes are available. Either so-called male or female patterns have been reported in most of the cases regarding which such information has been recorded to date,[11a-e] but mosaic or other abnormalities do occur. In the patient decribed by Hirschhorn[12a] and colleagues, bone marrow cultures revealed an XO/XY pattern. The possibility of artefacts, however, must be kept in mind. Finally, true hermaphroditism has occurred in individuals with an XX pattern, lacking therefore the so-called male Y chromosome.[13a-c]

II. Laboratory Findings Other Than the Nuclear Chromatin and Sex Chromosomes

From Table 1 it is evident that the hallmark of an untreated adrenogenital syndrome of the spontaneous type is a marked elevation of the urinary 17-ketosteroids. This is not true, however, of the iatrogenic type which follows antepartum therapy of the mother with testosterone and progesterone.

Urinary gonadotropins are increased above normal only in Turner's and in Klinefelter's syndromes. In the spontaneous adrenogenital syndrome they are frequently decreased.

The estrogen levels in urine are markedly decreased or absent in the female Turner syndrome and normal or above normal in the Klinefelter and the adrenogenital syndromes.

Biopsies reveal a reversible suppression of ovarian development and function in the pseudohermaphroditic female. Follicle formation and ovulation also are inadequate or absent in Turner's syndrome and in true hermaphroditism. An XO pattern, however, may be compatible with reproduction.

Spermatogenesis usually is defective or absent in all of the disorders listed in Table 1, except that spermatogenesis and fertility can occur in Klinefelter's syndrome.

III. Management of Intersex Problems

Therapy is determined by the nature of the disorder as identified by means of nuclear chromatin and other laboratory studies, and biopsy or surgical exploration.

In female pseudohermaphroditism arising from abnormal steroidogenesis the urinary 17-ketosteroids can be restored to normal by replacement-displacement amounts of hydrocortisone, i. e., 10 to 20 mg. per day. This also returns the accelerated somatic and skeletal growth rates to normal and eliminates the virilizing trend.

Internal genitalia can return to normal structure and function. If the child is still young plastic procedures on the clitoris and other abnormalities of the external genitalia can be undertaken to produce a female configuration. If, however, the child is well oriented toward a male pattern of behavior and feeling, it may be best from the psychologic viewpoint to continue in this direction. This will necessitate removal of the ovaries and internal genitalia, plastic procedures on the clitoris, and prolonged or life-long administration of testosterone.

In the iatrogenic testosterone or progesterone induced type of female pseudohermaphroditism no hormonal therapy is needed but plastic repair procedures usually have to be undertaken. This is also true of the female pseudohermaphroditism which occurs with congenital anomalies of the gastrointestinal and urinary tract, or is of undetermined origin.

In male pseudohermaphroditism or testicular feminization, removal of the testes from their labial, inguinal, or intra-abdominal position is indicated, and is to be followed by estrogen therapy through middle life.

Turner's syndrome in the female usually requires only cyclic estrogen or estrogen-progesterone therapy to permit full development of sex hair and other secondary sex characteristics. Fertility of course is usually not restored in ovarian agenesis but may be present or induced in the milder forms.

In the external males with Turner's syndrome androgen therapy may be necessary for full masculinization but this usually will not increase spermatogenesis.

Klinefelter's syndrome requires no androgen therapy unless one wishes to suppress eunuchoid body development during pubescence and adoles-

cence. Gynecomastia, when present, may be disfiguring and necessitate surgical correction.

In true hermaphroditism, therapy is determined by the sexual orientation of the patient. Excision of the appropriate gonadal tissue is undertaken, leaving behind ovarian or testicular tissue as indicated. Supplementary androgen or estrogen therapy is then administered in accord with need.

Summary

1. The various types of abnormal development of internal and external genitalia may be divided into female and male pseudohermaphroditism, the chromosomal intersexes (female and male Turner's syndrome and Klinefelter's syndrome in males), and the true hermaphrodites. In addition ambiguity or suppression of sex may be a feature of the triple-X or so-called superfemale chromosomal pattern, may accompany a dysgerminoma or teratoma of the ovary or result from the complete absence of gonads and genitalia.

2. These individual categories can be identified by means of the nuclear chromatin and sex chromosomes, the levels of 17-ketosteroids and gonadotropins, and by biopsy or surgical exploration.

3. Therapy is determined by the disorder present, the sexual orientation of the patient, the anatomic limitations found, and the need for supplementary or replacement amounts of androgens or estrogens. Life-long hydrocortisone therapy is essential in the treatment of female pseudohermaphroditism resulting from abnormal steroidogenesis, if excessive androgen production and masculinization are to be suppressed.

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. . . to the discontented man no chair is easy.

BENJAMIN FRANKLIN.

Appendiceal Calculus in Children*

(A Pathognomonic Roentgen Sign of Appendiceal Pathology)

C. S. Chun, M. D., C. H. (Joseph) Chang, M. D., and John D. German, M. D.

Since Weisflog,[1] in 1906, reported the first case of roentgenographically diagnosed appendiceal calculus, the important clinical significance of the condition as an etiologic factor of impending serious appendiceal pathology has been well documented.[2-8] Though there are various clinical and radiological signs of appendiceal pathology, roentgenographic demonstration of the appendiceal calculus is a pathognomonic sign.

According to Boyd,[9] fecal concretions in the appendix are common and appendiceal calculi also are not uncommon in children.[3, 10]

The purpose of this paper is to reemphasize the importance of appendiceal calculi in children, especially to the pediatrician, the pediatric surgeon and the radiologist, and to report two cases to add to the literature.

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Case Reports

Case 1.—L. S. I., an 8-year-old white girl, was first admitted to Man Memorial Hospital on April 12, 1961, with an appendiceal abscess. The initial x-ray study of the abdomen revealed poor definition of the right psoas shadow, with minimal dilatation of small intestinal loops in the right lower quadrant. There also was noted extraluminal air in the right lower quadrant, with multiple air-fluid levels on the upright projection (Figure 1). No appendiceal calculus, however, was demonstrated at this time. The appendiceal abscess was conservatively treated and it gradually resolved. The patient was discharged April 22, 1961, recovered, and arrangements were made for her to come into the hospital for interval appendectomy. The interval appendectomy, however, was refused by the mother although she was warned about the possibility of future complications.

On July 2, 1961, the patient was readmitted to the hospital with acute abdominal pain and vomiting. Physical examination revealed an acutely ill child with a temperature of 100°F. The abdomen was slightly distended. There was definite muscle spasm, with tenderness and rebound tenderness in the right lower quadrant. On rectal examination, there was slight tenderness high on the left but very marked tenderness high on the right. The white blood count was 14,000 with 83 per cent segmented forms and 5

Figure 1—Case 1. Initial roentgenogram of abdomen showing poor definition of right psoas shadow, with minimal dilatation of small intestinal loops in right lower quadrant. No appendiceal calculus was demonstrated.

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Submitted to the Publication Committee, December 12, 1961.

stabs. Urinalysis was essentially negative and x-ray study of the chest also was negative.

Abdominal roentgenograms showed an oval calcific density in the right lower quadrant, suggesting an appendiceal calculus (Figures 2a and 2b), also localized mild reflex ileus in the right lower quadrant, and the preoperative diagnosis was acute appendicitis.

Appendectomy was accomplished with extreme difficulty due to the previous appendiceal abscess and the superimposed acute appendicitis. There was purulent material in the peritoneal cavity, a smear of which showed pus cells without organisms, and a fecalith was found in the base of the appendix. Because of the purulent material in the abdominal cavity and the extent of the inflammatory process in the right lower quadrant, also because of the difficult appendectomy, the patient was given penicillin and streptomycin postoperatively.

A postoperative x-ray of the abdomen obtained for comparison with that made preoperatively showed disappearance of the appendiceal calculus (Figure 3).

The patient was discharged on the fifth postoperative day in good condition.

Comment.—An interesting point in this case is that the appendiceal calculus was demonstrated by x-ray three months after the initial appendiceal abscess.

Case 2.—J. R. H., a 15-year-old white boy, was admitted to Man Memorial Hospital on April 26, 1961 with pain in the right lower quadrant of the abdomen. Three days previously, he was seen in the emergency room because of nausea, vomiting, epigastric pain and diarrhea. The examination was entirely negative and it was felt that the patient had acute gastroenteritis. No x-ray study of the abdomen was made.

Physical examination on admission revealed pain localized in the right lower abdominal quadrant. The temperature was 101.2 F. Bowel sounds were slightly diminished. There was localized tenderness and rebound tenderness in the right lower quadrant. On rectal examination, there was slight tenderness high on the left, with an extremely tender, firm mass palpable high on the right which was thought to represent an acutely inflamed appendix wrapped in omentum.

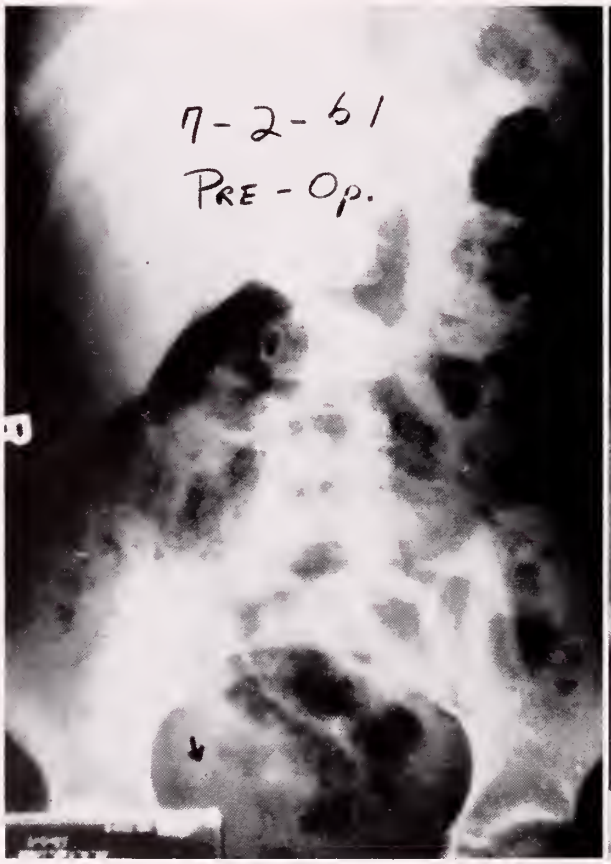

Figure 2a—Case 1

Figure 2b—Case 1

Figure 2a—Case 1. Preoperative study of abdomen reveals an oval calcific density (arrow) in the right lower quadrant suggesting an appendiceal calculus. (2b—Case 1) Close-up of right lower quadrant showing an appendiceal calculus (arrow).

The white blood count was 16,800 with 77 per cent segmented forms. Urinalysis was not remarkable. Chest x-ray was within normal limits. The abdominal roentgenogram revealed a large, laminated, calcific density in the right lower quadrant suggesting an appendiceal calculus (Figures 4a and 4b). A preoperative diagnosis of acute appendicitis was made.

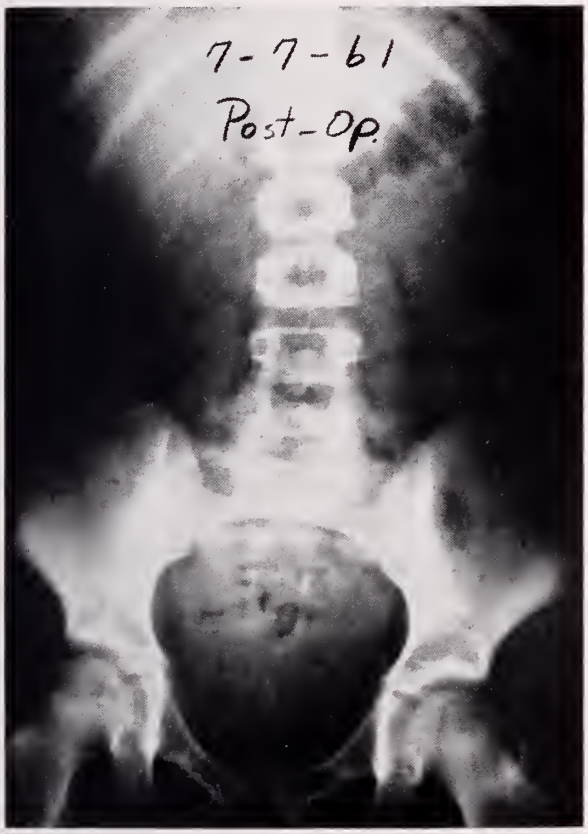

Figure 3—Case 1. Postoperative study of abdomen showing disappearance of calculus.

At operation, a well localized inflammatory process about the appendix was found, and an acutely inflamed, gangrenous and probably perforated appendix was removed. Its proximal portion was not distended. Its distal two-thirds, however, showed marked gangrene and distention, conditions usually seen in obstructive appendicitis. The wound was drained down to the peritoneum, the drain removed on the fourth postoperative day, and on the fifth day postoperatively, the patient was discharged from the hospital. An x-ray film of the abdomen after surgery revealed disappearance of the appendiceal calculus (Figure 5).

Comment.—The confusing initial clinical picture suggesting acute gastroenteritis delayed the diagnosis in this case, and is one of the most common causes of such delay in acute appendicitis, especially in children. An x-ray of the abdomen in such cases is extremely helpful and demonstration of an appendiceal calculus has diagnostic value.

The case re-emphasizes the value of an abdominal x-ray in the acute abdomen, regardless of the patient's age.

Discussion

The clinical findings in acute appendicitis vary and early signs and symptoms, especially in children, are easily mistaken for those of acute gastroenteritis or upper respiratory infection. The presence, however, of an appendiceal calculus in a patient with acute abdominal symptoms is a reliable sign of acute appendicitis.

Various other roentgen signs of acute appendicitis are well described by Soteropoulos and Gilmore.[11]

The appendiceal calculus usually is situated in the right lower quadrant. Occasionally, however, it is also shown to be movable.[3] The shape frequently is oval, but can be otherwise. Most appendicoliths are laminated in appearance, but solid and mottled varieties also are seen. Though the size of the appendiceal calculus is variable, most are from 5 to 20 mm. in diameter.[12] The number present varies from one to two. Shahan,[13] however, reported 23 in one case.

Numerous conditions can simulate appendiceal calculus radiographically. The differential diagnosis is not difficult, however, particularly in children. Ureteral and biliary calculi are rare in children and pyelographic and cholecystographic studies will yield the diagnosis. Calcified mesenteric lymph nodes usually show a mulberry appearance with an irregular outline. Bone islands may be a source of confusion, but these can be confirmed by multiple radiographic projections. Bone islands always are situated in the bone and do not change position. Phleboliths and vascular plaques are rare in children. Calcified appendiceal epiploicae also are rare and usually are movable throughout the abdominal cavity in different positions. Barium enema in doubtful cases will help in differentiation in the absence of acute abdominal signs.

The incidence of appendiceal calculus is variable according to different observers. Wangensteen and Bowers,[14] in their series, reported an appendicolith in 44 per cent of acute, suppurative cases and in 80 per cent of cases in which the inflamed appendix was gangrenous. Kjellman,[15] from his survey of the literature, reported that appendiceal calculus is demonstrable by x-ray in from 4 to 15 per cent of acute cases.

The chemical composition of appendiceal calculi has been studied by many investigators.[3, 16, 17, 18] They have shown that the inorganic materials are mainly calcium phosphate, and that the organic matter chiefly is represented by cellulose, mucus, fibrin and a small amount of fat.

Formation of appendiceal calculi most likely is due to stasis and inadequate emptying from fibrosis of the wall, kinking, peri-appendiceal adhesions, adjacent lymph node enlargement and other similar factors. Demonstration of an appendiceal calculus indicates the long-time presence of appendiceal pathology and in such a case, there is always danger of acute obstructive appendicitis, with gangrene and perforation.

The mortality rate of perforated appendicitis is considerably higher than that of nonruptured acute appendicitis, and is approximately 5 per cent.[19] Prophylactic appendectomy in cases of appendiceal calculus is proposed by Childe,[3] also by Halch and Homa.[19] We too recommend it, especially in children, even though the patient is asymptomatic.

Summary

Two cases of appendiceal calculus in children with acute appendicitis are reported.

The literature is reviewed, and the clinical significance, incidence, pathogenesis, differential diagnosis and management are discussed.

Appendiceal calculus is the only pathognomonic roentgen sign of appendiceal pathology. Fecaliths in the appendix are common and appendiceal calculi are not infrequent in children.

Demonstration of appendiceal calculus indicates the long-time presence of appendiceal pathology with impending serious complications. Prophylactic appendectomy is recommended in cases of appendiceal calculus in children, even though the patient is without symptoms.

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Figure 4a—Case 2

Figure 4b—Case 2

Figure 4a—Case 2. Preoperative roentgenogram showing a large laminated calcific density (arrow) in the right lower abdominal quadrant suggesting an appendiceal calculus. (4b—Case 2) Close-up of right lower quadrant showing appendiceal calculus (arrow).

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Figure 5—Case 2. Postoperative roentgenogram showing disappearance of appendiceal calculus.

The Principal Ingredient

FEWER than two per cent of doctors are guilty of overcharging, yet the whole profession is blamed. In general, if the physician will take the time to explain each item on the bill, patients will be satisfied, particularly when explanation is offered in advance. There will be no dissatisfaction about charges if both the doctor and the patient agree that the fee is earned on the basis of services rendered.

My father, a physician, frequently refers to his relationship with patients by the statement, "I have *worked* for that family for many years." How often do doctors feel that they are "working for" a family? A few seem to feel, instead, that they are generous in condescending to accept a patient. When physicians assume responsibility for care of the sick, they must also accept the fact that they are servants of mankind. They do not heal: They merely use the God-given resources which aid the body to return to a healthy state.

If free enterprise in the practice of medicine is to survive, doctors must take the responsibility of establishing a closer relationship with those people who entrust their lives to the care of medical practitioners. There is no single panacea for all members of the profession; each physician must evaluate himself from the patient's point of view, and then prescribe corrective measures if they are needed, but *dedication* must be the principal ingredient.—Robert Mayo Tenery, M. D., in Texas State Journal of Medicine.

Special Article

Deaths by Suicide in West Virginia (1960)

N. H. Dyer, M. D., M. P. H., and Paul B. Shanks, M. P. H.

In the calendar year 1960 the Division of Vital Statistics, State Department of Health, recorded 18,040 resident deaths. Of this number 249, or 1.4 per cent showed the cause of death as suicide. While this per cent of the total may not appear to be significant, the cause for concern is the marked increase in the 1960 figure over 1959. This cause of death increased from 192 in 1959 to 249 in 1960, an increase of 57, or 30 per cent. In 1960, for the first time, death by suicide became one of the ten leading causes of death in West Virginia with a rank of eighth.

Fifty of the state's fifty-five counties reported one or more deaths by suicide. No suicides were reported in Barbour, Calhoun, Pleasants, Ritchie and Webster Counties. The counties in which the 249 deaths occurred are shown on the attached map. The population of Kanawha County is approximately two-and-a-half times larger than that of any other county, and it reported the greatest number of suicides—a total of 30. But there is not a continued uniformity of suicides in relation to population in the ten most populous counties, as shown in Table 1.

TABLE 1

County	*Population*	*Population Rank*	*Number Suicides*	*Rank Compared with Population*
Kanawha	252,925	1	30	1
Cabell	108,202	2	12	4
Wood	78,331	3	5	8
Harrison	77,856	4	12	4
Raleigh	77,826	5	16	2
McDowell	71,359	6	10	5
Ohio	68,437	7	4	9
Mercer	68,206	8	9	6
Marion	63,717	9	7	7
Fayette	61,731	10	14	3
	928,590		119	

Raleigh County, the state's fifth largest county, was second in number of reported suicides. Fayette ranked tenth in population, but was third in the number of suicidal deaths. Both of these coal-producing counties have encountered great economic problems in recent years due mainly to reduced employment in the coal industry.

There is a normal relationship between population and suicides in the ten leading counties. The population of 928,590, as shown in the ten most populous counties in Table 1, is 49 per cent of the state's total population of 1,860,421. The 119 suicides reported from the ten leading counties is 48 per cent of the total state report of 249.

Submitted to the Publication Committee, February 8, 1962.

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At what age is death by suicide most likely to occur? Based on 1960 statistics the largest number of such deaths occurred between 50 and 59 years of age, as shown in Table 2. This is the age group in which these people should have reached the height of their most productive years, yet employment opportunities for them were few.

TABLE 2

Age Group	*Number Suicides*
1 - 9	..
10 - 19	4
20 - 29	26
30 - 39	42
40 - 49	40
50 - 59	62
60 - 69	41
70 - 79	29
80 - 89	4
Unknown	1
	249

The incidence of male suicide deaths exceeds that of female deaths by 65.4 per cent. This is reflected in Table 3.

TABLE 3

Color	*Sex*	*Number Suicides*	*Per Cent*
White	Male	205	82.3
White	Female	41	16.5
Non-white	Male	2	0.8
Non-white	Female	1	0.4
		249	100.0

A review of the death certificates of the 249 suicides revealed that they had been engaged in

a diversification of occupations as shown in Table 4.

TABLE 4

Occupation	*Number Suicides*
Manufacturing	40
Mining	31
Agriculture & Forestry	25
Wholesale & Retail Trade	22
Construction	18
Transp. & Communications	17
Public Administration	14
Professional & Related Services	7
Personal Services	7
Business & Repair Services	3
Entertainment & Recreation	1
Industry & Unclassified	64
TOTAL	249

TABLE 5

Methods of Suicide	*Number*	*Per Cent*
Firearms & Explosives	173	69.5
Hanging & Strangulation	32	12.9
Poisoning (All Forms)	17	6.8
Drowning	8	3.2
Cutting & Piercing Instruments	8	3.2
Jumping from High Place	7	2.8
Other & Unspecified Means	4	1.6
	249	100.0

By far the greatest percentage (69.5) of suicides used firearms and explosives to end their lives. This was followed by hanging and strangulation (12.9 per cent), and the third largest cause was poisoning (all forms), with 17 deaths recorded, or 6.8 per cent. A summary of suicidal methods is shown in Table 5.

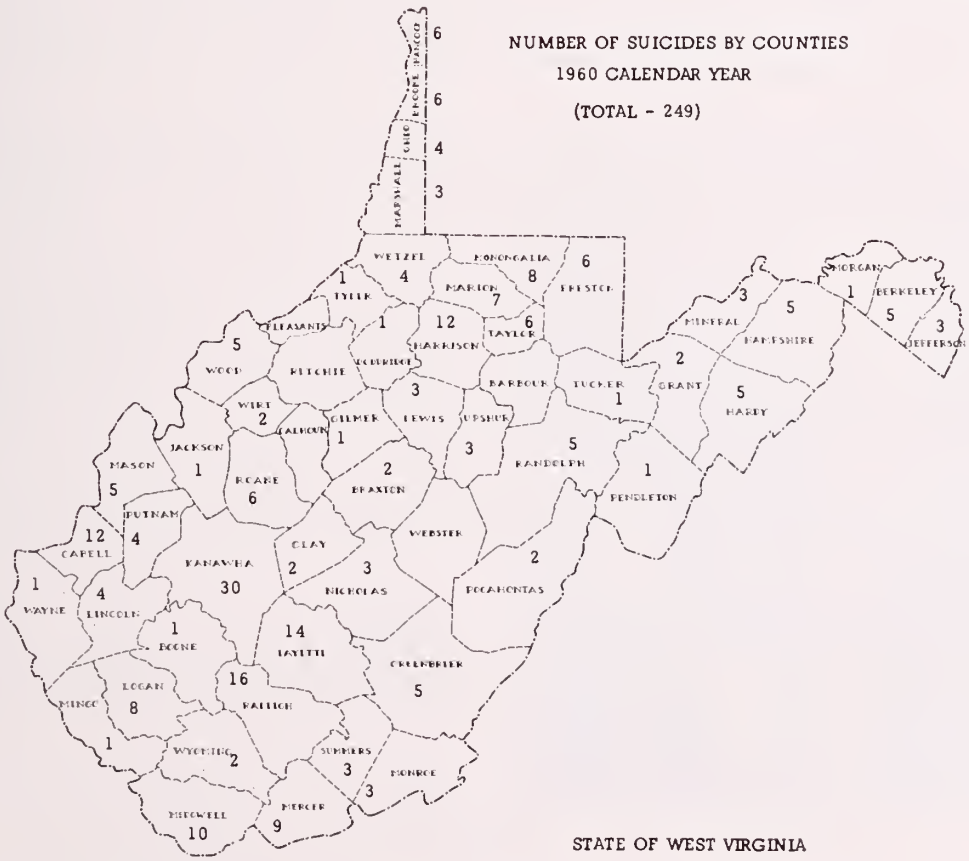
Summary

Deaths by suicide in 1960 were 30 per cent greater than in 1959. This increase, from 192 deaths in 1959 to 249 in 1960, placed suicide as the eighth leading cause of death. This is the first time suicidal deaths have appeared in the state's ten leading causes of death.

The 1960 report shows most suicides occurred between the ages of 50 and 59, and male suicide deaths exceed that of female deaths by 65.4 per cent.

Based on information recorded on death certificates most (40) of the persons committing suicide showed their employment as manufacturing. Second (31) were employed in the mining industry, and third (25), agriculture and forestry. Slightly more than one-fourth (25.7 per cent) of the reported suicidal deaths did not record information regarding occupation. If these data were available the above sequence might be altered.

No specific cause, or causes, for the 30 per cent increase in 1960 can be accurately determined from available information. From places of occurrance (Table 1), there is some indication that economic conditions may have been a factor for the marked increase in deaths by suicide.



The President's Page

Educate, Select and Elect

When President Kennedy on February 27, 1962, again requested Congress to pass H.R. 4222, as a preamble he made certain statements with which we all agree, as follows: "Basically, health care is a responsibility of individuals and families, of communities and voluntary agencies, of local and state governments. But the Federal Government shares this responsibility of providing leadership, guidance and support in areas of national concern."

It might be said that these basic tenets of responsibility have guided us as physicians in the care of the sick for many generations. Historically, it has been presumed the Federal Government would intervene only when the above system failed to provide for a need. When it was demonstrated that certain aged individuals who, though not indigent, were not financially able to provide medical care for themselves without undue hardship, the Kerr-Mills Law was passed by the Congress in September, 1960. This was commendable legislation designed to fill a void in our structure of medical financing. The Kerr-Mills Law provided assistance for those who needed help and was in accord with the precepts as outlined above.

Before this law could be implemented by the states, H.R. 4222 was introduced in the Congress. The bill cannot qualify as good legislation because it abrogates the basic right of the individual, the family, the community, and the State to care for their own. It substitutes compulsion for voluntarism so that the premise of helping those who need help is lost in all inclusive Federal controls.

Later, in the same message and under the misleading title of "Health Insurance for the Aged," the President stated: "Our social insurance system today guards against nearly every major financial setback: retirement, death, disability and unemployment. But it does not protect against the hardship of prolonged and expensive illness. Under our Social Security system, a retired person receives cash benefits to help meet the basic cost of food, shelter and clothing—benefits to which he is entitled by reason of contributions he made during his working years."

If H.R. 4222 were enacted into law there would be created for the first time a service benefit which has no wage or contribution relation to the beneficiary. In the past this wage-related cash benefit principle has been held to be the cornerstone of the Social Security system. The adoption of a compulsory health program under Social Security would merely create a tax whereby the younger taxpayer would provide care for the aged, whether they needed such care or not. By its very nature this program would be expanded with each succeeding Congress into ultimate completely Socialized Medicine.

In the next few weeks the Congress will be charged with making a crucial decision as to whether we are to continue our proven voluntary system which has provided the world's best medical care. While most of our Congressmen are not "in" on the conspiracy to socialize medicine as embodied in the "foot in the door" H.R. 4222, there are some who nonetheless are tempted to go along because of the political expediency of supporting the Administration in their biennial task of getting reelected. Fortunately for our country there is an ever increasing number of conservative legislators who are discovering that an informed electorate does not subscribe to a socialistic welfare state.

We must continue the program of education for our citizens, help select and elect a conservative Congress. These candidates will need not only our vote but our continuing support. This must be on a plane above partisan politics and without regard to party affiliation. We must all pledge ourselves to untiring efforts to combat our insidious slide toward Socialism if our nation is to survive.

D. E. Greeneltch, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone DIckens 4-4625.

EDITORIALS

THE NEW EDITOR

How fortunate is *The West Virginia Medical Journal* in having a capable man to fill the editorship left vacant by our beloved, long-time Editor, Dr. Walter E. Vest. This is certainly not an easy post to fill, considering the many accomplishments of the late Editor; however, Dr. George F. Evans has every qualification for the position.

His outstanding career qualifies him to speak on nearly every facet of medical practice. As a sanatorium superintendent Doctor Evans can speak on the state practice of medicine. From his long-time service on the Council of the West Virginia State Medical Association and as President of the Association he can speak for organized medicine. From his service on the Medical Licensing Board of West Virginia he can speak for medical education. From his constant interest and effort in the voluntary tuberculosis association he can speak regarding the physician's role in the voluntary health field.

Above all, as a physician devoted to the private practice of medicine Doctor Evans can speak with feeling about patients and their problems as seen each day.

All members of the West Virginia State Medical Association will join the Publication Committee in commending Doctor Evans for accepting this assignment. Not only do we wish him success but pledge every support.—W.L.C.

Dr. George F. Evans is a native of St. Marys, Ontario, Canada, and he received his M. D. degree from McGill University in Montreal. He served his internship and had postgraduate work

George F. Evans, M. D.

at hospitals in the eastern part of the United States.

Following his medical training, he became a member of the staff of Hopemont Sanitarium in Preston County, and later served as medical director and superintendent of that institution. He located in Clarksburg in 1934 for the practice of his specialty of internal medicine.

Doctor Evans served a term as president of the State Medical Association, 1958-59, and he has been a member of the Medical Licensing Board of West Virginia since 1949. He has been a member of the Publication Committee since 1956. He is a Fellow of the American College of Physicians and the American College of Chest Physicians, and he is a past president of the West Virginia Tuberculosis and Health Association.

He served overseas in the Medical Corps of the United States Army for three years during World War II, being honorably discharged with the rank of Lieutenant Colonel. He was decorated with the Legion of Merit for meritorious service in Algeria and Italy.

Doctor Evans was married in 1936 to Elah Frances Pettit, daughter of the late Dr. J. G. Pettit, former superintendent of Weston State Hospital and Hopemont Sanitarium.

SUICIDE

Elsewhere in this issue of *The Journal* appears an informative article by Dyer and Shanks which concerns suicide. The authors point out that there was a marked increase in the suicide rate in West Virginia in 1960 over that of 1959, bringing it up to near the national figure. It is a sobering thought that in the year 1960 death by suicide became one of the ten leading causes of death in the state—indeed, it ranked eighth. On the other hand, the question can well be raised why the suicide rate in West Virginia before 1960 did not approach the national figure.

In their summary the authors state that although the cause of the marked increase which occurred in 1960 cannot be accurately determined there is some indication that economic conditions may have been a factor.

Menninger[1] has written that once every minute, or even more often, someone in the United States either kills himself, or tries to do so, with conscious intent, and he points out further that about 60-70 times every day these attempts succeed. Shneidman and Farberow[2] have given a somewhat more conservative figure. They report that at least 16,000 persons take their own lives each year, but that this figure does not include covert or concealed suicide. Whatever the precise figure may be it is a large one, and, as mentioned previously, suicide in the United States ranks among the ten leading causes of death.

Shneidman and Farberow[3] in their researches on suicide have emphasized several important findings. They observed, for example, that three-fourths of the subjects they studied who committed suicide, had previously threatened or attempted to take their own life. The interpretation is, of course, that suicidal behavior must be taken seriously since the next suicidal gesture may be the final one. They observed also that half of the individuals who committed suicide did so within three months of having passed an emotional crisis, and after they appeared to be well on the way to recovery. Obviously this suggests that such patients should be carefully watched for at least 90 days after the period of attempted suicide. They observed further that a person who threatens suicide seems to be more emotionally disturbed than the person who actually attempts suicide, but both types of individuals must be carefully watched for at least three months.

It is generally conceded that the cause for suicide is often not known. Dyer and Shanks point out that economic reasons may have been the cause for the increase in suicide in 1960 in West Virginia. This may indeed be true, but it must be emphasized that in many causes economic considerations are not an important factor. It is well known, for instance, that in at least one Scandinavian country which takes care of its citizens "from the womb to the tomb" has an extremely high suicide rate.

Dr. Karl Menninger[1] has written that research studies in the important field of suicide have been neglected. The average normal person feels that suicide seems too dreadful to be conceivable, and actually there has been no organized interest in it. This is a great pity. The entire matter needs a sympathetic and intensive study. Much can be done in this area, and in many instances suicide can be prevented.

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[1]Shneidman, E. S., and Farberow, M. L.: *Clues to Suicide* (McGraw-Hill, New York, N. Y. 1957). p. v
[2]Ibid p. vii
[3]Ibid p. 9

Big Business and Getting Bigger

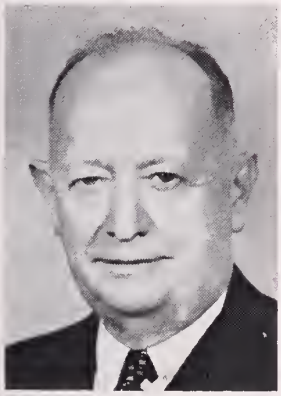
Health insurance organizations of the United States paid out an average of $17.3 million a day during 1961. This was an increase of $1.8 million per day over 1960. The yearly total adds up to $6.3 billion, $3.4 billion by insurance companies and $2.9 billion by Blue Cross-Blue Shield and independent plans, according to the Health Insurance Institute. The Institute estimates that 136 million persons are now protected by hospital insurance.—Journal, Indiana State Medical Association.

GENERAL NEWS

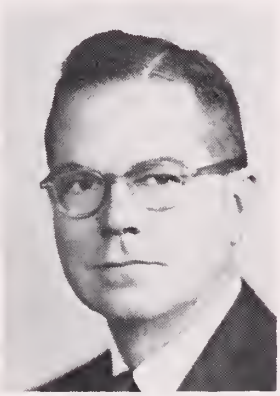
Drs. Middleton and Maumenee To Speak At 95th Annual Meeting

The Program Committee has announced that two distinguished physicians have been added to the list of guest speakers who will appear on the program at the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25.

Dr. Halvard Wanger of Shepherdstown, the Chairman, said that Drs. William S. Middleton of Washington, D. C., and Alfred E. Maumenee of Baltimore, have accepted invitations to present papers during the three-day meeting.



William S. Middleton, M. D.



Alfred E. Maumenee, M. D.

Doctor Middleton, who is Chief Medical Director of the Veterans Administration, will appear as a speaker at the second general session on Friday morning, August 24.

Doctor Middleton was born in Norristown, Pennsylvania, and he received his M.D. degree from the University of Pennsylvania School of Medicine in 1911. He served his internship at the Philadelphia General Hospital.

He served as Instructor, Professor of Medicine and Dean of the University of Wisconsin Medical School during the period from 1912 to 1955. He is presently Dean Emeritus and Professor of Medicine Emeritus at the University of Wisconsin Medical School.

During World War I, Doctor Middleton served with British and American Expeditionary Forces in France, 1917-19. In World War II, he was Chief Consultant in Medicine to the European Theatre of Operation, 1942-45. He served as Special Advisor to the Surgeon General of the Army during the Korean conflict.

He has been awarded honorary degrees by several universities in this country and abroad.

Doctor Middleton appeared as a speaker at the 90th Annual Meeting at The Greenbrier in 1957. He also was one of the principal speakers at Dedicatory Ceremonies for the Basic Sciences Building at the West Virginia University Medical Center in 1957.

Alfred E. Maumenee, M. D.

Dr. Alfred E. Maumenee, who is Professor of Ophthalmology at Johns Hopkins University School of Medicine, will appear as a speaker during the first general scientific session on Thursday morning, August 23.

He is a native of Mobile, Alabama, and was graduated from the University of Alabama. He received his M. D. degree from Cornell University School of Medicine in 1938.

Doctor Maumenee served as an intern and assistant resident in ophthalmology at Johns Hopkins Hospital, 1938-42, and was resident ophthalmologist, 1942-43. He served as a member of the faculty at Johns Hopkins from 1939 until 1948, at which time he was appointed Professor of Surgery in Ophthalmology at the Stanford University School of Medicine. He returned to Johns Hopkins as Professor of Ophthalmology in 1955.

Doctor Maumenee served as a Lieutenant in the Medical Corps of the United States Navy, 1944-46.

He is Ophthalmologist-in-Chief at Johns Hopkins Hospital and also serves as civilian consultant to Walter Reed Army Hospital, United States Naval Hospital in Bethesda, Maryland, and the Clinical Center of the National Institutes of Health.

Doctor Maumenee was certified by the American Board of Ophthalmology in 1943 and he is a member of the American Academy of Ophthalmology and Otolaryngology, and the American Ophthalmological Society. He is also a member of the Medical and Chirurgical Faculty of the State of Maryland and the American Medical Association.

Program Nearing Completion

The names of several other guest speakers were announced previously. They are:

Dr. I. S. Ravdin, Professor of Surgery and Vice President of Medical Affairs at the University of Pennsylvania; Dr. Irving S. Wright, Professor of Clinical Medicine at Cornell University Medical College; Dr. Stewart G. Wolf, Professor and Head of the Department of Medicine at the University of Oklahoma

School of Medicine; and Dr. H. L. Riva, Professor and Chairman of the Department of Obstetrics and Gynecology at Seton Hall College of Medicine.

Dr. George M. Fister of Ogden, Utah, who will be installed as President of the American Medical Association next month, will speak before the final session of the House of Delegates on Saturday afternoon, August 25. Dr. D. E. Greeneltch of Wheeling, President of the State Medical Association, will deliver his Presidential Address at the first session of the House of Delegates on Wednesday evening, August 22.

Additional information concerning the program will appear in future issues of *The Journal*. The complete program will be published in the Convention Number in August.

Heavy Room Reservations At The Greenbrier

Reservations for the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25, are approaching the 300 mark as this issue of *The Journal* goes to press.

The management has again assured Association officials that every effort will be made to arrange accommodations for all those who are interested in attending the convention. It is important, however, that reservations be made as soon as possible so that some idea may be had by the management concerning the total number of rooms that will be needed to house those attending the meeting in August.

Requests for rooms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, W. Va.

Relocations

Dr. Curtis E. Beam, who has been a member of the staff of Beckley Memorial Hospital, has moved to Pompano Beach, Florida. His office address is 2701 Atlantic Beach.

* * * *

Dr. Joseph N. Aceto of Wheeling has moved to Sunbury, Pennsylvania, where he is a member of the staff of the Department of Radiology at the Sunbury Community Hospital.

* * * *

Dr. Bascom B. Young, who has served as Director of the Charleston Mental Health Center since 1959, has accepted appointment as Chief of the Mental Hygiene Clinic at the Veterans Administration Hospital in Huntington.

PH Meeting in Roanoke

The 30th annual meeting of the Southern Branch of the American Public Health Association will be held at the Hotel Roanoke in Roanoke, Virginia, May 2-4. The annual meeting of the Virginia Public Health Association will be held on May 1.

TB and Health Assn. Meeting In Beckley, Oct. 10-11

The Annual Meeting of the West Virginia Tuberculosis and Health Association will be held at the Beckley Hotel in Beckley, October 10-11, 1962.

The West Virginia Thoracic Society, medical advisory section of the Tuberculosis and Health Association, will also hold its annual meeting in Beckley on October 10. Dr. Richard V. Lynch, Jr., of Clarksburg is president of the Thoracic Society.

On October 9, a postgraduate course in pulmonary and respiratory diseases will be presented under the direction of Dr. Charles E. Andrews, Associate Professor of Medicine and Chief of the Pulmonary Disease Section of the West Virginia University Medical Center. Doctor Andrews will be assisted by several prominent out-of-state physicians and the program will be confined to a discussion of non-tuberculous and tuberculous pulmonary diseases.

The West Virginia Tuberculosis and Health Association has been instrumental in the establishment of the Chair of Pulmonary Diseases at the Medical Center, Through an arrangement with the Medical Center, financial support has been given to the Department of Medicine to the extent of $10,000 per annum for the past three years. This money has been collected from various county tuberculosis associations in West Virginia.

SAMA Meeting in Washington

More than 2,000 medical students, interns and residents are expected to attend the 12th annual meeting of the Student American Medical Association which will be held at the Mayflower Hotel in Washington, D. C., May 10-13.

Outstanding leaders from medicine, government and the entertainment world will appear on the program. The scientific sessions will include a panel discussion on endocrinology and an address by Dr. W. Proctor Harvey of Washington who will discuss "The Clinical Spectrum of Primary Myocardial Disease."

Television's Ben Casey has been invited to speak before the House of Delegates on May 12. He will also receive an honorary membership in SAMA for his contributions to the public understanding of the responsibilities and work load of the resident physician.

Symposium at Saranac Lake

The 11th Annual Symposium for General Practitioners on Tuberculosis and other Pulmonary Diseases will be held at Saranac Lake, New York, July 9-13.

The five-day symposium will be sponsored by the American Thoracic Society, Saranac Lake Medical Society, New York State Academy of General Practice and College of General Practice, Canada.

The registration fee is $75 and sessions will be held at the Hotel Saranac and various sanitoria and laboratories in the Saranac Lake area. Further information may be obtained by writing Dr. John N. Haynes, General Chairman, P. O. Box 627, Saranac Lake, New York.

New Association Members

Dr. Charles B. Cobern, 1133 Market Street, Parkersburg (Parkersburg Academy). Doctor Cobern, a native of Washington, Pennsylvania, was graduated from Washington and Jefferson College and received his M. D. degree from Northwestern University Medical School in 1941. He interned at Cincinnati General Hospital, 1940-41, and had residency training in pathology and radiology. He served as a Captain in the Medical Corps of the United States Army, 1942-46, and was previously located at Johnstown, Pennsylvania. His specialty is radiology

* * * *

Dr. John M. Daniel, 104 Vine Street, Beckley (Raleigh). Doctor Daniel was born in Beckley and was graduated from the University of Virginia. He received his M. D. degree from the Jefferson Medical College of Philadelphia in 1956. He interned and served a residency at Charleston Memorial Hospital, 1956-59, and then served for two years as a Captain in the Medical Corps of the United States Air Force. His specialty is internal medicine.

* * * *

Dr. John W. English, Beckley Memorial Hospital (Raleigh). Doctor English, a native of Madison, Wisconsin, received his M. D. degree from the University of Wisconsin School of Medicine in 1955. He interned at Madison General Hospital in Madison, Wisconsin, 1955-56, and served a residency at Beckley Memorial Hospital, 1957-60. He served with the United States Navy, 1945-46, and his specialty is internal medicine.

* * * *

Dr. Nancy C. Flowers, 303 Crescent Road, Beckley (Raleigh). Doctor Flowers was born in McComb, Mississippi, and received her M. D. degree from the University of Tennessee College of Medicine in 1958. She interned at Roanoke Memorial Hospital in Roanoke, Virginia, 1958-59, and is currently serving a residency in internal medicine at Beckley Memorial Hospital.

* * * *

Dr. Frederick Moomau, Grant Memorial Hospital, Petersburg (Potomac Valley). Doctor Moomau, a native of Petersburg, was graduated from West Virginia University and received his M. D. degree from the University of Maryland School of Medicine in 1957. He interned at Washington Medical Center, 1957-58, and served a residency at the George Washington University Hospital, 1958-61. His specialty is internal medicine.

* * * *

Dr. Silva Jean B. Neilson, 2608 Valley View Drive, Bluefield (Mercer). Doctor Neilson was born in Lenoir, North Carolina, and received her M. D. degree from the University of Tennessee School of Medicine in 1958. She interned at the City of Memphis Hospital in Memphis, Tennessee, 1958-59, and was licensed to practice in West Virginia in 1961. She is a member of the staff at the Bluefield Mental Health Clinic.

"One can never pay in gratitude; one can only pay "in kind" somewhere else in life.—Anne Morrow Lindbergh.

Jerry Gould Named Member Of Headquarters Staff

Jerry Gould of Charleston has been named assistant to the executive secretary of the West Virginia State Medical Association. The appointment was announced by Dr. John W. Hash of Charleston, Chairman of the Council.

Jerry Gould

Mr. Gould, who has been a member of the staff of United Press International in Charleston for the past five years, assumed his new duties on May 1.

A native of Mannington, Mr. Gould began his newspaper career with *The Charleston Gazette* in 1946. He later served as sports editor of the *Parkersburg News* and as a staff sports writer for the *Charleston Daily Mail* for nine years prior to joining the UPI staff in 1957.

His experience with UPI ranged from coverage of the Kennedy-Humphrey primary campaign in West Virginia to coal mine disasters and floods. He was a member of the team covering the 1962 budget session of the State Legislature.

He married the former Jean Ann Smoot, a registered nurse, and they have seven children.

Monograph on 'Medical Malpractice' Available to Physicians

A new monograph on "Medical Malpractice" was published recently by the Defense Research Institute, Inc., a non-profit national organization composed of defense lawyers (see book review elsewhere in this issue of *The Journal*).

The following paragraph taken from the foreword outlines the reasons for the publication of this valuable monograph:

"The likelihood of being sued for malpractice is so great today that the practicing physician must recognize it as a "definite occupational hazard," according to Dr. David B. Allman, past president of the American Medical Association. For this reason, the Defense Research Institute, Inc., presents this monograph on Medical Malpractice with two primary objectives: (1) to provide practical help for lawyers engaged in defending medical malpractice cases and (2) to supply information that physicians and medical societies can use in preventing the increase in that type of litigation."

Stanley C. Morris, prominent lawyer of Charleston, has been active for many years in the organization and is currently serving as chairman of the board.

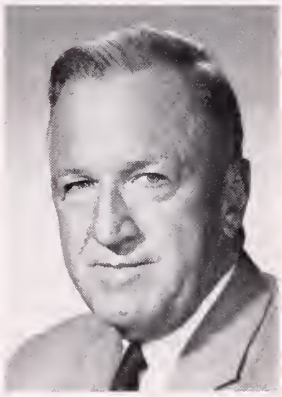
The price of the monograph is 50¢ and physicians may obtain copies by writing the Defense Research Institute, Inc., P. O. Box 126, University Station, Syracuse 10, N. Y.

Annual Meeting, W. Va. Chap., AAGP In Charleston, May 25-27

More than three hundred physicians are expected to attend the 10th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice which will be held at the Civic Center in Charleston, May 25-27.

Dr. Don S. Benson of Moundsville, general chairman of the convention, announced that 18 prominent physicians and surgeons have accepted invitations to appear as guest speakers on the scientific program. General scientific sessions will be held mornings and afternoons on Saturday and Sunday, in addition to an afternoon session on Friday, May 25.

O. Spurgeon English, M. D.



Charles A. Doan, M. D.

Heart Association Program

Dr. Randall Connolly of Vienna, the president, will call the meeting to order officially at 1:45 P.M. on Friday, May 25. The invocation will be given by the Rev. John S. Lyles of Dunbar, and addresses of welcome will be delivered by the Honorable John Shanklin, Mayor of the City of Charleston; Dr. D. E. Greeneltch of Wheeling, President of the West Virginia State Medical Association; and Dr. Robert C. Bock of Charleston, President of the Kanawha Medical Society.

Dr. Halvard Wanger of Shepherdstown, chairman of the program committee, has announced that the scientific session that afternoon will be sponsored by the West Virginia Heart Association. Dr. Morris H. O'Dell of Charleston, the president, will preside.

The speakers and their subjects are as follows:

2:15—"Treatment of Resistant Congestive Heart Failure."—William L. Proudfit, M. D., Department of Cardiovascular Disease, The Cleveland Clinic.

2:45—"Problems Related to Digitalis Therapy in the Treatment of Congestive Heart Failure."—Leonard Scherlis, M. D., Associate Professor of Medicine, University of Maryland School of Medicine.

3:45—"Recognition of Coronary Artery Disease As A Cause for Congestive Heart Failure."—Earl K. Shirey, M. D., Department of Pediatric Cardiology and Cardiac Laboratory, The Cleveland Clinic.

4:15—Panel Discussion.

Saturday Morning, May 26

9:00—"Aging as the Endrocrinologist Views It."—Thomas H. McGavack, M. D., Chief of Intermediate Service, Veterans Administration Hospital, Martinsburg, West Virginia; and Professor Emeritus of Clinical Medicine, New York Medical College.

9:30—"Management of the Psychosomatic Patient" (Actual Case Presentation and Discussion).—O. Spurgeon English, M. D., Professor and Head of the Department of Psychiatry, Temple University School of Medicine.

11:00—"A Round-Trip Journey from Anesthesia to Psychiatry via the Fluorinated Ethers."—John C. Krantz, Ph.D., Professor and Head of the Department of Pharmacy, University of Maryland School of Medicine.

11:30—"Aplastic and the Leukemic States: Today's Major Hematologic Challenge."—Charles A. Doan, M. D., Emeritus Dean and Professor of Medicine, Ohio State University College of Medicine.

12:00—Panel Discussion.

Saturday Afternoon

2:00—"The Management of Allergies."—Chauncey D. Leake, Ph.D., Professor of Pharmacology, Ohio State University College of Medicine.

2:30—"The Nausea Vertigo Syndrome as Seen by a Clinician."—Charles M. Caravati, M. D., Professor of Clinical Medicine, Medical College of Virginia.

3:30—"What It is Like to Be a Patient."—Thomas E. Rardin, Sr., M. D., Assistant Professor of Preventive Medicine, Ohio State University College of Medicine.

4:00—"Viral Pleuropericarditis."—Philip Tumulty, M. D., Associate Professor of Medicine, Johns Hopkins University School of Medicine.

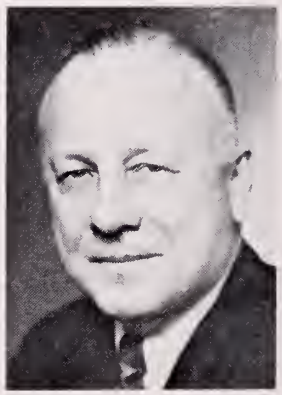
4:30—Panel Discussion.

Sunday Morning, May 27

9:00—"Inborn Errors of Metabolism."—Earl H. Baxter, M. D., Professor and Head of the Department of Pediatrics, Ohio State University College of Medicine.

9:30—"Growth Failure in Infancy."—Stuart S. Stevenson, M. D., Professor and Chairman of Pediatrics, Seton Hall College of Medicine.

Chauncey D. Leake, Ph.D.



Thomas H. McGavack, M. D.

10:00—"The Modern Approach to the Problems of Ectopic Pregnancy."—Bayard Carter, M. D., Professor and Head of the Department of Obstetrics and Gynecology, Duke University School of Medicine.

11:00—"Toxemia of Pregnancy."—D. Frank Kaltreider, M. D., Professor of Obstetrics and Gynecology, University of Maryland School of Medicine.

11:30—Panel Discussion.

Sunday Afternoon

2:00—"The Acute Abdomen."—Manuel E. Lichtenstein, M. D., Associate Professor of Surgery, Northwestern University School of Medicine; and Professor of Surgery, Cook County Graduate School of Medicine.

2:30—"Burns."—George H. Yeager, M. D., Professor of Clinical Surgery and Director of Clinical Research, University of Maryland School of Medicine.

3:00—"Cutaneous Manifestations of Systemic Diseases."—Raymond C. V. Robinson, M. D., Associate Professor of Dermatology, University of Maryland School of Medicine.

3:30—Panel Discussion.

Moderators of Panel Discussions

The following members of the Academy will serve as moderators of panel discussions which will follow the presentation of papers at each general session: Drs. Clark K. Sleeth of Morgantown, Carl B. Hall of Charleston, Jerome C. Arnett of Rowlesburg and Jack Leckie of Huntington.

Doctor Benson To Be Installed as President

Dr. Don S. Benson of Moundsville, the president elect, will be installed as president during the meeting, succeeding Dr. Randall Connolly of Vienna.

Other officers are Dr. Joseph A. Smith of Dunbar, secretary; and Dr. Peter A. Haley of Charleston, treasurer. Dr. J. Keith Pickens of Clarksburg, immediate past president, is chairman of the Board of Directors and Dr. Seigle W. Parks of Fairmont, Editor of *Mister Doc*, official publication of the Chapter.

Pre-Convention Meetings

The Chapter's Board of Directors will meet at the Daniel Boone Hotel on Thursday evening, May 24. The House of Delegates will be convened at the Civic Center at ten o'clock on Friday morning, May 25, and the official order of business will include an address by the president, Dr. Randall Connolly.

Doctor Chauncey D. Leake Banquet Speaker

Dr. Chauncey D. Leake of Columbus, Ohio, will be the speaker at a banquet which will be held at the Civic Center on Saturday evening, May 26.

Doctor Leake, who is Professor of Pharmacology at the Ohio State University College of Medicine, will discuss "Standards of Measurement and Nursery Rhymes."

He is a past president of the American Association for the Advancement of Science and of the Society for Pharmacology and Experimental Therapeutics. He is currently serving as president of the American Association for the History of Medicine and the Society for Experimental Biology and Medicine. His interests have been in anesthesia, chemotherapy and general pharmacology.

Prior to joining the faculty at Ohio State, Doctor Leake served for ten years as director of the University of Texas Medical Branch in Galveston. He has wide interests and speaks knowingly of architecture, the communicative arts, ancient history and the romance languages, as well as matters pertaining to science.

Doctor Leake will also present a paper on "The Management of Allergies" before the general scientific session on Saturday afternoon.

Committee Chairmen

In addition to Dr. Halvard Wanger, the chairman, the other members of the program committee are Drs. Clark K. Sleeth of Morgantown and Carl B. Hall of Charleston.

Dr. William D. Crigger of South Charleston is chairman of the committee on local arrangements and Mrs. Joseph A. Smith, Jr., of Dunbar, chairman of the entertainment program for wives of visiting physicians.

Baltimore Physician To Receive 1962 Goldberger Award

Dr. E. A. Park of Baltimore, whose findings played a major role in eliminating rickets as an important health problem for American children, will be honored with the American Medical Association's highest award in clinical nutrition during the AMA meeting in Chicago.

Doctor Park, Professor Emeritus of Pediatrics at Johns Hopkins Hospital, has been named by the AMA Board of Trustees to receive the 1962 Joseph Goldberger Award. A pioneer in the field of human nutrition in the United States, Doctor Park will receive a commemorative plaque and $1,000.

Doctor Park will deliver the annual Goldberger lecture at the meeting. His subject will be "The Imprinting of Nutritional Disturbances on the Growing Bone."

Interns Must Know Their Stuff

By overruling a motion to certify the record, the Ohio Supreme Court let stand a verdict of $45,000 against Fairview Park Hospital, Cleveland (Larry Koubeck, appellee, v., Fairview Park Hospital, appellant, 35 Ohio Bar No. 2, Hospitals).

In refusing to review the negligence verdict against the hospital, the court in effect upheld the argument of the plaintiff's attorney that interns and residents working in a hospital emergency room must meet the standards of qualified physicians rather than be regarded as medical students. It was alleged that some of the trouble arose from the fact that the intern rendering the service did not understand or speak English well enough to carry on an intelligent conversation with the patient.—Ohio State Medical Journal.

'Beware of Medical Quacks'

"Beware of Medical Quacks" is the title of a new booklet which is available for distribution in physicians' offices. The booklet has been highly recommended by the American Medical Association. The author is Donald Cooley, who has written numerous medical books and booklets.

The cost of the booklet is five cents per copy. Orders should be placed with the AMA Department of Investigation, 535 North Dearborn Street, Chicago 10, Illinois.

University Hospital Honored By National Magazine

The West Virginia University Medical Center was designated as the "Modern Hospital of the Month" in the March issue of the publication, *The Modern Hospital.* The Medical Center was featured in a six-page article appearing in that issue.

An award is made monthly to a hospital being built under the Federal Hospital Survey and Construction Act.

The awards are made on the basis of excellence of architectural design, functional planning, economy of construction and operation, and proper provision for hospital needs of the community as evaluated by members of a committee following a study of the architects' plans.

Architects for the WVU Medical Center are C. E. Silling and Associates of Charleston, and the associate architects are Schmidt, Garden and Erikson of Chicago. James A. Hamilton and Associates of Minneapolis were consultants to the University.

No Place for Economy

The human factor cannot be legislated or ignored—all cigarettes may be the same but a man will literally walk a mile for his particular brand. It is beyond understanding why the physician-pharmacist-patient team should be forced into accepting pharmaceuticals on a generic—or cheaper basis. Economy has no place when the human body, and its wellbeing, is concerned. —D. F. Robinson, M. D., Director, Oklahoma University Student Health Service.

Dept. of Medicine and Religion Established by AMA

A Department of Medicine and Religion was recently created within the American Medical Association to encourage closer relationships between physicians and clergymen in patient care.

The Rev. Dr. Paul B. McCleave, who formerly served as pastor of the First Presbyterian Church in Bozeman, Montana, has been appointed director of the new department. The department will foster close physician-clergy relationships through programs carried out on the local medical society level and tailored to fit local needs.

"Too often today," Doctor McCleave says, "we forget to consider 'the whole man.' We forget the patient and parishioner's needs in total health—physical, mental and spiritual. The three are not separable."

Doctor McCleave feels that the best patient care is achieved when physicians and clergymen are able to share mutual concern for the patient and when each contributes his special talents to the problem at hand.

Terminal illness, he points out, is an excellent example of an area in which the clergy can be of particular help to physicians.

Doctor McCleave says his department also plans close liaison with hospital chaplains, mental health authorities and pastoral clinical training centers, furnishing any assistance it can. Similar liaison is planned in the area of medical, theological and nursing school curriculums.

West Virginia University Hospital—"Modern Hospital of the Month." This designation was conferred by the publication "The Modern Hospital" in its March 1962 issue. Six members of the original building committee that guided the planning and design of the Medical Center are pictured above. Seated, left to right, Dr. E. J. Van Liere, Dean Emeritus of the School of Medicine, and Dr. John M. Slack, Chairman of the Committee. Standing, left to right, Dr. John J. Lawless, Dean Clark K. Sleeth, and Drs. J. Clifford Stickney and Reginald F. Krause.

Theresa Snaith Clinical Meeting In Morgantown on May 17

The first annual Theresa Snaith Clinical Meeting, sponsored by the West Virginia Pediatric Society, will be held at the West Virginia University Medical Center in Morgantown on Thursday, May 17.

Doctor Snaith, who died on June 11, 1961, practiced her specialty of pediatrics in Weston for more than 30 years. She was the first woman to receive an M. D. degree from the University of Maryland School of Medicine, and the first woman to serve on the Council of the West Virginia State Medical Association.

Dr. William G. Klingberg, chairman of the program committee, announced that the Society has extended a cordial invitation to all state physicians to attend the one-day meeting.

The registration desk will open at 10 A.M. and there will be a tour of the Medical Center at 11 o'clock. Dr. Clark K. Sleeth, Dean of the WVU School of Medicine, will welcome the guests at the opening of the scientific session that afternoon. The following program will be presented by members of the School of Medicine faculty:

"Pediatric Ophthalmology."—Robert R. Trotter, M. D., Chairman, Department of Ophthalmology.

"Pediatric Cancer and Cancer Chemotherapy."—Barbara Jones, M. D., Assistant Professor of Pediatrics.

"Convulsive Disorders in Children."—John Nelson, M. D., Chairman, Division of Neurology; and Robert Nugent, M. D., Assistant Professor of Surgery, Division of Neurosurgery.

"Clinical Pathological Conference."—Thomas G. Potterfield, M. D., Charleston, Chairman, and Wilhelm Albrink, M. D., Professor and Chairman of the Department of Pathology.

Dr. Paul A. Miller, who was inaugurated last month as president of the University, will be the speaker at a banquet which will be held at the Hotel Morgan.

A program for wives of visiting physicians has been arranged by Mrs. William G. Klingberg and Mrs. Russell Lucas.

Further information may be obtained by writing Dr. William G. Klingberg, WVU School of Medicine, Medical Center, Morgantown, W. Va.

Reduced Drug Costs

Competition explains why antibiotics now cost about one-fifth of what they cost a decade ago, on the average. It explains why penicillin prices are now 5 per cent of what they were after World War II. It explains why Insulin costs 6 per cent of what it cost 30 years ago; why streptomycin prices dropped 40 per cent in less than a year; why Salk vaccine prices have been cut in half.

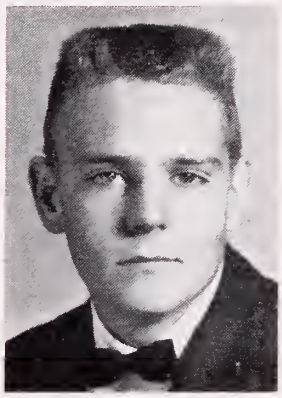
Chemotherapy has helped bring good health to three million Americans who wouldn't be alive today if prewar rates still applied.—Edward R. Annis, M. D., in Medical Economics.

To me the charm of an encyclopedia is that it knows —and I needn't.—Francis Yeats-Brown.

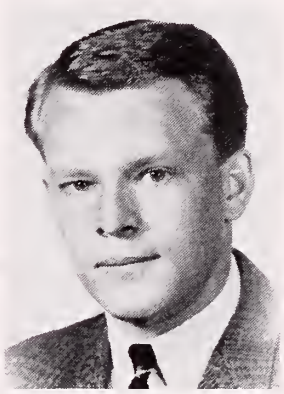
Kanawha County Students Selected For Scholarship Awards

Paul Brooks of Sissonville and Paul E. Lanham of Charleston have been selected by the Medical Scholarships Committee of the West Virginia State Medical Association as the 1962 recipients of the four-year scholarship awards to the West Virginia University School of Medicine.

Announcement of the awards was made by Dr. Russel Kessel of Charleston, the chairman, following a meeting of the committee at the Medical Center in Morgantown on April 15.



Paul Brooks



Paul E. Lanham

The scholarships, each worth $4,000, are awarded annually to two students enrolled in the first-year class at the School of Medicine. The two recipients will accept the awards formally during the 95th Annual Meeting of the State Medical Association at The Greenbrier in White Sulphur Springs in August.

Mr. Brooks, 21-year-old son of Mr. and Mrs. Arlo P. Brooks of Sissonville, was graduated from Sissonville High School. He had his pre-medical training at Morris Harvey College and West Virginia State College. He is married and the father of two children.

Mr. Lanham, 22-year-old son of Mr. and Mrs. Emmet O. Lanham of Charleston, was graduated from Stonewall Jackson High School. He is a student at the University of Virginia in Charlottesville.

The two men will begin their studies in September as freshmen in the WVU School of Medicine. They are the fifth and sixth students to receive scholarships under the program inaugurated by the State Medical Association in 1958. The Association awarded one scholarship per year until 1961, and the House of Delegates voted last August to provide an additional annual scholarship.

Mr. Larry Hemmings, recipient of the first scholarship, will receive his M. D. degree in June. He will serve his internship at the U. S. Naval Hospital in Bethesda, Maryland. Scholarships also were awarded to Terry T. Tallman of Alma, Tyler County, in 1959; Glenn Buchanan of Gilbert, Mingo County, in 1960; and to Clare D. Edman of Parkersburg in 1961.

Medical Self-Help Program In West Virginia

After nearly two years of planning and preparation, West Virginia now has a program under way to train at least 450-thousand persons in techniques of medical self-help for use in disaster situations.

State Health Director N. H. Dyer has termed the effort "the most massive and ambitious short-termed educational effort in history." He said the eventual goal was to have at least one person in every family prepared to administer lifesaving services during man-made or natural catastrophies.

Writing in a recent issue of the health department's "State of the State's Health," Doctor Dyer noted that the program is being sponsored in West Virginia by the Committee on Medical Emergencies and Civil Defense of the State Medical Association. The committee has the assigned responsibility of maintaining medical supervision and instruction throughout the state; providing medical sponsorship, expanded function training to paramedical groups, and assisting the State Department of Health in developing plans and establishing guidelines for provision of trained, qualified instructors.

The preparedness effort also has the endorsement of the American Medical Association, the U. S. Public Health Service and the Office of Civil Defense of the Department of Defense.

Supervision is provided by the State Department of Health, fulfilling its responsibilities for emergency health services in civil defense, Doctor Dyer observed. Consultation is given by the State Department of Education and general administration by the State Department of Civil and Defense Mobilization.

Doctor Dyer emphasized the essential difference in medical self-help and first aid. While first aid normally assumes that proper medical assistance can be obtained within a short time, he explained, medical self-help presupposes that professional assistance will not be available for a much longer period.

"We recognize that laymen can only be expected to perform a few of the lifesaving skills practiced by the medical profession," he asserted, "but it is also significant that a knowledge of these few techniques can mean the difference between life and death in an emergency."

He said that the necessity for such training has been brought into focus by the threat of national disaster involving extended periods of isolation. Also that there is an ever-increasing threat of nuclear accidents because of an emphasis on industrial uses of the new energy form.

"With all our research and knowledge in the field of industrial safety and increased mastry over natural phenomena, we still have periodic catastrophies involving explosions, slides, floods, fires, and escaping gasses," the health director said. "Increased usage of nuclear energy will add radiation in possible lethal quantities to this list."

Doctor Dyer said there are 12 lessons in the course which require about 16 hours of classroom work. Included among the subjects are: fallout shelters; hygiene, sanitation and vermin control; water and food; shock; bleeding and bandaging; artificial respiration; fractures and splinting; transportation of injured; burns; nursing care; infant and child care; and emergency childbirth.

He noted that courses are getting under way in many sections of the state and called upon physicians, educators, and local civil defense and health officials to get behind the effort. Any group of 25 persons may apply for the course through county offices of civil defense and health departments.

He also urged local health officers to work with physicians and other health disciplines in planning for staffing of 10 civil defense 200-bed emergency hospital units which are now located in Hancock, Ohio, Monongalia, Marion, Wood, Harrison, Boone, Raleigh, Mercer and McDowell counties.

Minimum staffing requirements for the hospitals call for more than 50 persons, including seven physicians, with a radiologist and an anesthesiologist; ten nurses, including two with experience in supervision of central supply rooms; two pharmacists; two laboratory technicians; one x-ray technician; 25 male medical aids, and six female messengers, Doctor Dyer explained.

He said that a training unit is available at the Public Health Center in South Charleston which can be used at its present location or transported to other sites within the state. Also that consultation and supervision of training activities is available from the State Health Department's Office of Health Mobilization.

In another issue of the publication, the health director urged a crash program for control of highway accidents.

Doctor Dyer said the situation is "getting out of hand" and stressed the need for a complete re-evaluation of existing statutes controlling driver licensing. He called for a study to incorporate the latest findings of medical and safety authorities, especially as they relate to human factors in accidents.

"Certainly the study group should include representatives of state and local medical organizations, official and voluntary mental and public health agencies and safety councils," he said.

Doctor Dyer noted that much research is currently underway to study the relationship between certain physical defects, disease and motor vehicle accident records. He called attention to the American Medical Association's "Medical Guide for Physicians," which can be used as a reference for determining a patient's fitness to drive a motor vehicle.

"With all the attention being paid to highway safety, it should be evident that the death rate would be al-

New Telephone Number

The telephone number has been changed in the headquarters offices of the West Virginia State Medical Association in Charleston. The new number is 343-4607.

most inconceivable if so many agencies were not putting a tremendous effort into education and law enforcement," declared the health director. "But it should be equally evident that existing safety education and enforcement of present laws are not enough to cope effectively with an ever-increasing problem."

He said that most authorities consider accidents "a preventable disease," but it is possible that their cause and prevention will prove as diverse as the many diseases we can now understand and cure.

Emphasizing the necessity for specific recommendations to be presented to the Governor and the Legislature, Doctor Dyer said that West Virginia should take the initiative and lead the way for the nation with a bold, imaginative approach toward prevention of highway accidents.

Medical Meetings, 1962

The following is a partial list of national, state and district medical meetings scheduled for 1962:

May 17—Theresa Snaith Clinical Meeting, WVU Medical Center, Morgantown.
May 25-27—W. Va. Chap. AAGP, Charleston.
June 6-8—W. Va. PH Association, Huntington.
June 21-25—ACCP, Morrison Hotel, Chicago.
June 24-28—AMA Annual Meeting, Chicago.
June 28-29—Seminar on "The Adolescent," WVU Medical Center, Morgantown.
Aug. 16-18—W. Va. Hospital Assn., White Sul. Springs.
Aug. 23-25—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 13-16—PG Institute, Martinsburg.
Sept. 20-21—W. Va. Heart Assn., Morgantown.
Oct. 9-11—W. Va. TB and Health Assn., Beckley.
Oct. 22-23—American Cancer Soc., New York.
Nov. 2-4—ACP Regional Meeting, White Sul. Springs.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 24-25—ACCP, Ambassador Hotel, Los Angeles.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.

Booklet on Anticoagulants Available For Distribution to Patients

Dr. Morris H. O'Dell of Charleston, president of the West Virginia Heart Association, has announced that a new pamphlet entitled "Anticoagulants, Your Physician and You," is now available for distribution by physicians to patients being treated with anticoagulants.

The pamphlet is intended to reinforce the verbal explanation and advice given by physicians when introducing anticoagulant therapy. It explains the importance of periodic laboratory tests, warns against possible added effects of other drugs taken without a physician's prescription, and reminds patients to mention their anticoagulant medication to other physicians or dentists from whom treatment may be sought.

Physicians may obtain copies of the pamphlet and anticoagulant identification cards by writing the West Virginia Heart Association, Box 5336, Capitol Station, Charleston, West Virginia.

U. S. Leads in Medical Sciences

Never before in the 999 centuries of man's previous existence on earth has the standard of medical care been higher. Never before have we had the skills and the tools to cope with disease more effectively. Never before has progress in the health sciences come more rapidly. Whether or not we are ahead of Russia or the rest of the world in science generally, I am not qualified to judge. But I can say without fear of contradiction that we lead the world in the medical science, the invention of new and better drugs, and the provision made for the physical and mental well-being of our American people.—Theodore G. Klumpp, M. D., President, Winthrop Laboratories.

A meeting of the Publication Committee was held in Charleston on March 25. Dr. George F. Evans of Clarksburg (seated, right), was named Editor succeeding the late Dr. Walter E. Vest. Other members present were, left to right, Drs. E. Lyle Gage of Bluefield and E. J. Van Liere of Morgantown. Standing, Drs. Halvard Wanger of Shepherdstown and William L. Cooke of Charleston.

Two-Week Camping Period Planned At Camp Kno-Koma

Camp Kno-Koma, a summer camp for diabetic children of West Virginia, will be open for its 13th Annual Session from July 22 until August 4. The camp is located at the Galahad site on Blue Creek in Kanawha County, 31 miles northeast of Charleston.

Fifty-six diabetic boys and girls from many parts of the state will participate in the unique camping program which features the advantages of a normal summer camping experience in the out-of-doors, under the medical supervision vital to the diabetic child.

The medical staff, consisting of two doctors, two nurses, a laboratory technician and a dietician, donates

Fishing is among the activities planned for children attending Camp Kno-Koma. The summer camp for diabetic children will be open during a two-week period, July 22 to August 4, and children between the ages of 7 and 15 are eligible to attend.

its services. Campers are encouraged to develop self-reliance as early as possible by administering their own individual requirements of insulin, diet, and exercise for maintenance of good diabetic control.

Camping activities include swimming, fishing, hiking, nature-study, crafts, archery and other activities found at summer camps.

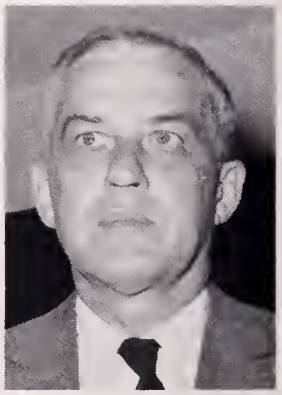
Diabetic children between the ages of 7 and 15 are eligible to attend the camp. There is no set fee for West Virginia residents, although parents are urged to contribute as much as possible toward the cost ($70 per camper). Financial aid is available to parents who cannot afford the registration fee.

State physicians are invited to enroll their young diabetic patients in the camp. An open-house will be held at Camp Galahad on Sunday, May 20.

Further information and application forms may be obtained by writing to Camp Kno-Koma, 1115 Quarrier Street, Charleston 1, West Virginia.

Dr. Paul H. Revercomb Elected Vice President of ACP

Dr. Paul H. Revercomb of Charleston was elected Vice President of the American College of Physicians during the annual meeting of that organization in Philadelphia, April 9-13.



Paul H. Revercomb, M. D.

Doctor Revercomb, who has been active in the College for many years, is a past governor of the West Virginia Chapter and also served a term on the ACP Credentials Committee.

A native of Covington, Virginia, he received his M. D. degree from the University of Virginia School of Medicine. He served his internship at the University of Pennsylvania Hospital and had residency training at Massachusetts General Hospital in Boston. He is certified by the American Board of Internal Medicine.

Doctor Revercomb has practiced in Charleston since 1934 and he is a past president of the Kanawha Medical Society.

Dr. R. U. Drinkard of Wheeling was reelected Governor of the West Virginia Chapter, ACP.

Dr. Franklin M. Hanger of Staunton, Virginia, was installed as president, succeeding Dr. Chester M. Jones of Boston. Dr. Wesley W. Spink of Minneapolis was named president elect and Drs. Marshall N. Fulton of Providence, Rhode Island, and Willis M. Fowler of Iowa City, Iowa, were also named vice presidents.

Tobacco Addiction

If one accepts the definition of addiction as the compulsive use of a substance known to be detrimental to health then the experience of countless millions habituated to the use of tobacco, especially in paper wrapped form, proves the validity of this designation.

Interesting comparison can be made of the relative public health aspects of enslavement to tobacco, to narcotics, and to alcohol.

Tobacco is closely implicated in the deaths of more than 25,000 individuals in this country under the category of bronchogenic carcinoma alone, and there is evidence now accumulating that smoking also helps to boost the mortality due to vascular diseases.

The mortality directly caused by narcotic addiction is trivial by comparison in spite of all the dramatic and expensive *cops and robbers* activity imposed by an unsound prohibition law.

There has been initiated only recently an intelligent attempt to appraise the enormous health problem connected with alcohol addiction after longstanding experimentation with ineffectual prohibition measures.

Constructive action against tobacco addiction is not possible until its true nature and magnitude are generally recognized.—Westchester Medical Bulletin.

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SEARLE

Research in the Service of Medicine

WVU Medical Center
—News—

EACH of the 15 medical students comprising the first group to receive M. D. degrees at the West Virginia University School of Medicine has accepted an internship appointment, effective July 1, 1962. Thirteen of the 15 secured posts which had been designated previously as the first choice of each respective individual.

Five students will remain in West Virginia for their internship training, and five will go to various military hospitals to begin to discharge their requirement for military service. The remaining five are widely distributed over the United States.

Although the group is too small to consider as setting any pattern, it is believed that this is a good distribution for so small a group. As larger classes are graduated in future years, it is expected that the same number of students will accept military internships.

Dean Clark K. Sleeth reported that most of the present group taking such internships have expressed the intention of returning to practice in West Virginia after discharging their military duties.

Internship Appointments

A list of the students, together with home addresses and internships accepted follows:

Richard B. Arnold, Huntington, Queens Hospital, Honolulu Hospital, Honolulu, Hawaii.

Halbert E. Ashworth, Charleston, U. S. Naval Hospital, Pensacola, Florida.

Frederick Cooley, Nitro, Memorial Hospital, Charleston.

Basil D. Cutlip, Webster Springs, U. S. Air Force Hospital, Lackland Air Force Base, San Antonio, Texas.

Francis A. Goad, Clendenin, West Virginia University Hospital.

Jesse S. Griffith, Charleston, Charleston General Hospital.

Louis Groves, Jr., Meadow Bridge, Memorial Hospital, Charleston.

Larry Hemmings, St. Mary's, U. S. Naval Hospital, Bethesda, Maryland.

Charles L. Ladwig, Clarksburg, George Washington Medical Center, Washington, D. C.

Charles W. Lewis, Huntington, Fitzsimmons U. S. Army Hospital, Denver, Colorado.

George H. Nelson, Morgantown, Medical College of Georgia, Talmadge Hospital, Augusta, Georgia.

Joseph B. Reed, Burlington, Memorial Hospital, Charleston.

Joseph A. Ruggiero, Fairmont, U. S. Naval Hospital, Bethesda, Maryland.

• **Compiled from material furnished by Cletis Pride, Public Information Officer, West Virginia University Medical Center, Morgantown, W. Va.**

Kenneta J. Shaffer, Morgantown, University of Kansas Hospital, Kansas City, Kansas.

David L. White, Bridgeport, Mound Park Hospital, St. Petersburg, Florida.

Miscellaneous

Dr. K. J. Laidler, Chairman of the Department of Chemistry at the University of Ottawa, Canada, was the guest speaker at a seminar held at the Medical Center on March 23. His subject was "Enzymes and Their Action."

Doctor Laidler is the author or co-author of a number of textbooks, including "Theory of Rate Processes," "Chemical Kinetics," "The Chemical Kinetics of Enzyme Action," and "The Chemical Kinetics of Excited States."

Two University surgeons have been awarded a $14,370 renewal of a federal grant to continue their development in 1962 of man-made replacements for human heart valves.

The work is being carried on by Dr. Herbert E. Warden, associate professor of surgery, and Dr. Thomas J. Tarnay, resident in surgery, under sponsorship of the National Institutes of Health of the Department of Health, Education and Welfare. The grant is being used to fabricate and test prosthetic heart valves to be used as replacements for valves which have been badly scarred by rheumatic fever.

Remarkable Progress

Present indications are that in the sixties our growth will be even more fabulous than it was in the fifties and the forties. In that two-decade period more effective new drugs to prevent, diagnose and treat countless illnesses were discovered than in the entire period of recorded medical history. Do you realize that 80 per cent of the prescriptions now written could not have been prescribed 10 years ago, that 1¼ million Americans are alive today because of new treatments in the past 10 years, and that five years have been added to man's lifespan in the last few decades.—Leonard W. Larson, M. D., President, American Medical Association.

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children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L.: M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

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The Month in Washington

• From the Washington Office of the American Medical Association.

SUPPORTERS of the King-Anderson bill stepped up their campaign as the House Ways and Means Committee neared a showdown vote on the legislation which would provide limited health care for the aged under Social Security.

The Kennedy Administration took over the leadership in the drive with the President accepting an invitation to address a rally at Madison Square Garden in New York City on May 20, sponsored by the National Council of Senior Citizens for Health Care Through Social Security.

Grass Roots Pressure

The Administration also was organizing citizens' committees in individual states to whip up grass roots pressure for the bill. The President was asking prominent persons, such as former Democratic Gov. and U.S. Sen. Edwin C. Johnson in Colorado, to head such committees.

After personally pledging their support to the legislation in a White House call on the President, 27 physicians formed The Physicians Committee for Health Care for the Aged Through Social Security headed by Dr. Caldwell B. Esselstyn of New York City, president of the Group Health Association of America. Most of the 27 are educators, hospital administrators or in other administrative posts. A majority are members of the AMA.

Pointing out that the White House was able to muster only an insignificant number of doctors for the King-Anderson bill, an AMA spokesman said at least 90 per cent of the nation's 261,000 physicians are opposed to the legislation.

The intensified Administration drive made it imperative that physicians and other opponents of the Social Security approach go all-out at this time in their efforts against the King-Anderson bill.

A vote was expected in the Ways and Means Committee in May or June at the latest.

Sen. Robert S. Kerr (D., Okla.), reaffirmed his opposition to the King-Anderson bill but said he expected it would come up on the Senate floor for a vote. He said he and Rep. Wilbur D. Mills (D., Ark.), chairman of the Ways and Means Committee, were conferring on legislation that would expand the Kerr-Mills program—which has the wholehearted support of the AMA—to cover more aged persons.

Under the leadership of Rep. William E. Miller (R., N.Y.), who is also chairman of the Republican National Committee, some Republican Congressmen got behind the so-called Bow bill which would permit aged persons to reduce their federal income taxes by up to $125 a year to cover health insurance premiums. The government also would issue to persons 65 years and older who pay no income taxes, or less than $125, a certificate with which to purchase health insurance.

Type III Oral Polio Vaccine

The Public Health Service licensed Type III oral poliomyelitis vaccine but left the decision to local health officials and physicians as to whether the oral or the Salk killed vaccine, or both, would be used this year.

Types I and II oral polio vaccine had been licensed last year and Type III was the last of the series needed for protection against all three types of polio. Production and availability of the oral vaccine will be a major factor in the extent of its use this year.

The PHS conclusion on local immunization programs was recommended by a special advisory committee to the Surgeon General and was in line with a policy adopted by the AMA House of Delegates at Denver last November.

The PHS gave five guidelines for the local programs:

1. Organizers of community drives must be assured that adequate supplies are available before such programs are undertaken.
2. All persons in those groups selected by the community should receive vaccine regardless of past polio immunization history.
3. In general, vaccination programs using either vaccine must have careful planning and achieve a maximum of support from official and voluntary health and medical groups.
4. The plans should assure the ready availability of the vaccine in all areas of the community and for all persons within the selected target groups. Special emphasis must be directed to those areas and population groups having the lowest levels of immunization. Community-wide programs should achieve the immunization of the maximum number of persons, but no less than 80 per cent of the pre-school children in all socio-economic groups.
5. A continuing program of immunization of infants should be incorporated as an essential feature of all organized community-wide programs.

The PHS also recommended that the three types of oral vaccines be administered sequentially, each in monovalent form at intervals of about six weeks.

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Obituaries

ARTHUR E. BAYS, M. D.

Dr. Arthur E. Bays, 78, of Montgomery, died on March 24 at a hospital in that city following a short illness.

Doctor Bays, who was a native of Nallen, Fayette County, had been actively engaged in practice in Montgomery from 1913 until his recent illness.

He received his M. D. degree from the University of Maryland School of Medicine in 1913 and was licensed to practice in West Virginia the same year. He was a member of the Fayette County Medical Society, West Virginia State Medical Association and American Medical Association. He also served as college physician for several years at West Virginia Institute of Technology.

Besides his widow, he is survived by a daughter, Mrs. Brough Treffer of Huntsville, Alabama; a son, William G. Bays of Alexandria, Virginia; a brother T. L. Bays of Ormond Beach, Florida; and five grandchildren.

* * * *

ALVIN GOSHORN BOWLES, M. D.

Dr. Alvin Goshorn Bowles, 74, of Beckley, died at a hospital in that city on April 7 following an illness of several months.

Doctor Bowles was born at Hamlin, Lincoln County, on September 23, 1887. He was graduated from Marshall University and received his M. D. degree from the University of Louisville in 1909. He served his internship at Louisville City Hospital.

He was licensed to practice in West Virginia in 1909 and served as company physician at Glen White for 35 years. He moved to Beckley in 1945 and continued to practice until 1951 when he retired. He was awarded a fifty-year plaque from the Raleigh County Medical Society in 1960.

He was vice president and director of the Beckley National Bank. He served a term as president of his local society and was also a member of the West Virginia State Medical Association, Southern Medical Association and American Medical Association.

His only survivor is his wife, Mrs. Ruth Pearl Bowles.

* * * *

DONZEL D. CHAPMAN, M. D.

Dr. Donzel D. Chapman, 88, of Weston, died on April 1 at a hospital in that city following a short illness.

Doctor Chapman, who was a native of Spencer, was born on September 9, 1873, son of the late Dr. D. W. and Martha Wease Chapman. He received his M. D. degree from the Barnes Medical College in St. Louis in 1903.

He was appointed assistant superintendent of Weston State Hospital in 1927. The following year he was transferred to Spencer State Hospital where he served as superintendent until 1932, at which time he moved to Weston where he engaged in the practice of medicine until the time of his recent illness.

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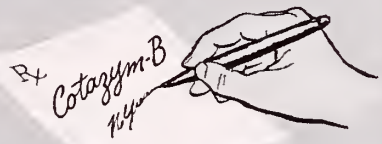

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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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He was a former member of the Central West Virginia Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by two sons, Daniel H. Chapman of Redlands, California, and William D. Chapman of Weston; a daughter, Mrs. Thresia M. Riley of Vadis; and three sisters and fourteen grandchildren.

* * * *

MELVIN WOOD McGEHEE, M. D.

Dr. Melvin Wood McGehee, 56, of Huntington, died at his home in that city on April 10 following a long illness.

Doctor McGehee, who was a past president of the West Virginia Academy of Ophthalmology and Otolaryngology, was born at Norfolk, Virginia, on September 14, 1905, son of Mrs. Stella Wood McGehee of Valdosta, Georgia, and the late Lee Franklin McGehee. He was graduated from the University of Virginia and received his M. D. degree from the University of Virginia School of Medicine in 1932. He served his internship at Memorial Hospital in Orange, New Jersey, 1932-33, and had residency training at the New York Postgraduate Hospital, 1933-36.

In 1936, he practiced for nine months in Raleigh, North Carolina, before joining the staff at Laird Memorial Hospital in Montgomery. He remained in Montgomery until 1945 at which time he relocated his practice in Huntington.

He was certified by the American Board of Otolaryngology in 1942 and he was a member of the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology. He was also a member of the Cabell County Medical Society, West Virginia State Medical Association and the American Medical Association.

Besides his mother, he is survived by his wife, Margaret Meyers McGehee; two daughters, Mrs. James W. Fisher of Indianapolis, Indiana, and Miss Jane McGehee at home; a son, Peter McGehee at home; and two grandchildren.

* * * *

ELMER E. WATSON, M. D.

Dr. Elmer E. Watson, 82, of Kingwood, died suddenly on April 1 at a hospital in Mill Valley, California. Dr. and Mrs. Watson had spent the winter at their home in Balboa, California.

Doctor Watson, who practiced for many years in Albright, was born in Sinclair, Preston County, on October 8, 1879, a son of the late William A. and Nancy Sinclair Watson. He was graduated from the University of Cincinnati College of Medicine in 1908. He was licensed to practice medicine in West Virginia that same year.

Doctor Watson was one of the organizers of the Albright National Bank and became its first president in 1913. He served one term as a member of the House of Delegates from Preston County, 1933-35.

He was an honorary member of the Preston County Medical Society, West Virginia State Medical Association and American Medical Association.

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E. C. Voss, M. D.

Eye, Ear, Nose and Throat:
A. J. Berlow, M. D.

Ophthalmology:
Robert A. Dye, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Barbara Karrer, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
JoAnn Hastings
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Evelyn Forester, R. T.

Business Administration:
John H. Clark, Manager
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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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INDICATIONS: VISTARIL is effective in premenstrual tension, the menopausal syndrome, tension headaches, alcoholic agitation, dentistry, and as an adjunct to psychotherapy. It is recommended for the management of anxiety associated with organic disturbances, such as digestive disorders, asthma, and dermatoses. Pediatric behavior problems and the emotional illnesses of senility are also effectively treated with VISTARIL.

ADMINISTRATION AND DOSAGE: Dosage varies with the state and response of each patient, rather than with weight, and should be individualized for optimum results. The usual adult oral dose ranges from 25 mg. t.i.d. to 100 mg. q.i.d. Usual children's oral dose: under 6 years, 50 mg. daily in divided doses; over 6 years, 50-100 mg. daily in divided doses.

Parenteral dosage for adult psychiatric and emotional emergencies, including acute alcoholism: .M.—50-100 mg. Stat., and q.4-6h., p.r.n. I.V.—50 mg. Stat., maintain with 25-50 mg. I.V. q.4-6h., p.r.n.

SIDE EFFECTS: Drowsiness may occur in some patients; if so, it is usually transitory, disappearing within a few days of continued therapy or upon reduction of dosage. Dryness of mouth may be encountered at higher doses.

PRECAUTIONS: Drowsiness may occur in some patients. The potentiating action of hydroxyzine should be taken into account when the drug is used in conjunction with central nervous system depressants. Do not exceed 1 cc. per minute I.V. Do not give over 100 mg. per dose I.V. Parenteral therapy is usually for 24-48 hours, except when, in the judgment of the physician, longer-term therapy by this route is desirable.

SUPPLIED: VISTARIL *Parenteral Solution* (hydroxyzine hydrochloride)—10 cc. vials, 25 mg. per cc. and 50 mg. per cc.; 2 cc. ampules, 50 mg. per cc. VISTARIL *Capsules* (hydroxyzine pamoate)—25, 50, and 100 mg. VISTARIL *Oral Suspension* (hydroxyzine pamoate)—25 mg. per 5 cc. teaspoonful.

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Besides his widow, he is survived by a daughter, Mrs. Andrew Bailey of Los Angeles; a son, James W. Watson of Mill Valley, California; a sister, Mrs. Ida Bucklew of Baltimore; four grandchildren and one great grandchild.

The Need for Public Education

There is a profound need for public education of parents and school personnel to help build good eating habits for our children.

The unintentionally pernicious habit of selling confectionary foods in school to finance activities should be discouraged. Candy and soft drink machines should be replaced with fruit, sandwich, nut and milk dispensers.

Effective parent education could result in improved eating habits in the home. There should be less eating in front of television and less consumption of the refined sweets and beverages advertised there. Skilled personnel, trained to break down public inertia to this problem, needs to be provided.

The medical profession should lead in this endeavor as an integral part of its professional and community responsibility.—Robert L. Jackson, M. D., in Missouri Medicine.

Some people are always grumbling because roses have thorns: I am thankful that thorns have roses.—Alphonse Karr.

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County Societies

BARBOUR-RANDOLPH-TUCKER

Mr. Cecil Dickson of Washington was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker County Medical Society which was held at the City Restaurant in Elkins on March 15.

Mr. Dickson, who is a legislative representative of the American Medical Association in Washington, discussed the "King-Anderson Bill and the New Frontier." He said the bill has tremendous emotional support in the cost figures which are unreal but made palatable to Congress. He also said supporters of the bill are attempting to secure the votes of 17-million persons over the age of 65.

The Society voted to place advertisements in local newspapers in opposition to enactment of the King-Anderson Bill.

Dr. A. C. Thompson, the president, presided at the meeting which was attended by 20 members and guests. —A. Kyle Bush, M. D., Secretary.

* * * *

KANAWHA

Dr. D. E. Greeneltch of Wheeling was the guest speaker at the regular monthly meeting of the Kanawha Medical Society which was held at the Daniel Boone Hotel in Charleston on April 10.

Doctor Greeneltch, who is president of the West Virginia State Medical Association, presented a brief account of the history of the medical aid for the aged program in the State and he also discussed H.R. 4222, the King-Anderson bill, which would place such care under the Social Security system.

Another speaker was Mr. Darrell Young of Charleston, a representative of the insurance companies in the State. He voiced strong opposition to enactment of the King-Anderson type legislation.

Dr. Robert C. Bock, the president, presided at the dinner meeting.

* * * *

MERCER

Dr. Joe E. McCary presided at the regular monthly meeting of the Mercer County Medical Society which was held at the University Club in Bluefield on March 19.

Dr. James E. McGee, Jr., presented three interesting case reports and his talk was illustrated by x-ray films.

During the business meeting, Drs. E. Lyle Gage, L. J. Pace and E. W. McCauley volunteered to participate in the medical self-help education program. There was also considerable discussion concerning the MAA program and pending national legislation of interest to the medical profession.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. Allen E. Yeakel was the guest speaker at the

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regular monthly meeting of the Monongalia County Medical Society which was held at the Hotel Morgan in Morgantown on March 6.

Doctor Yeakel, who is Assistant Professor of Anesthesiology at the West Virginia University School of Medicine, presented an interesting paper on "The Problem of the Full Stomach."

Dr. C. Truman Thompson, the president, presided at the business meeting and he announced the appointment of a committee to study the possibility of storing old records at the University Library.

Dr. J. C. Pickett announced that the Council of the West Virginia State Medical Association had endorsed the National Blue Shield Plan for Senior Citizens. The Society went on record as approving the proposed plan.

Drs. Pickett, E. F. Heiskell, Jr. and H. A. Rich were appointed to serve on a review committee to meet with officials of the District Welfare Department.—C. A. Logue, M. D., Acting Secretary.

* * * *

WYOMING

The regular quarterly meeting of the Wyoming County Medical Society was held at the Cow Shed in Pineville on March 11. The members were joined by their wives at a dinner which was held prior to the business meeting.

Dr. George F. Fordham, the president, reported that he had appointed Dr. B. W. Steele as a member of the Review Committee in District No. 5 which will meet at frequent intervals with District Welfare Officials. He

Radiology:
KARL J. MYERS, M. D.

Clinical Pathology:
E. E. MYERS, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Anatomic Pathology:
S. D. WU, M. D.

Dentistry:
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explained that the purpose of the meetings will be to help process questionable vouchers and resolve differences which might arise on the local level in connection with the MAA program.

The members voted to arrange one meeting a year at the Glass House in Beckley, or any other location that the Society desires. The first meeting will be held in September and Dr. Ross E. Newman was requested to make arrangements for the dinner and a guest speaker.

Doctor Fordham also reported that the Society had been requested by Mrs. Clarence Clowers, public health nurse, to discuss the possible development of a well-baby clinic at Bud, West Virginia. Following discussion, the Society gave its approval to the establishment of such a clinic by the Health Department.—Frank J. Zsoldos, Vice President.

The Dangers of Specificity

The flow of new and potent drugs today compels the physician to continue his postgraduate education as he never had to before. The more specific the drug—and every effort of pharmaceutical research is bent toward making drugs more pinpointed in action against particular conditions—the greater the likelihood of some unwanted side reaction.

Much pharmaceutical advertising warns the buyer not to use the product. It's rather like an ad for a washing machine which says, "This is a good washing machine but don't put a shirt into it or you may ruin it. It does a good job on sheets but is lousy on socks."—William B. Graham, President, Baxter Laboratories.

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Side Effects: Panmycin Phosphate is well tolerated clinically and has a very low order of toxicity comparable to that of the other tetracyclines. Side reactions are infrequent and consist principally of mild nausea and abdominal cramps.

Leukopenia has occurred occasionally in patients receiving novobiocin. Rarely, other blood dyscrasias including anemia, pancytopenia, agranulocytosis and thrombocytopenia have been reported. In a recent report it was observed that three times as many newborn infants receiving novobiocin developed jaundice as control infants. For this reason, administration of novobiocin to newborn and young infants is not recommended, unless indication is extremely urgent because of serious infections not susceptible to other antibacterial agents.

The development of jaundice has also been reported in older individuals receiving Albamycin. Serious liver damage has developed in a few patients, which was more likely related to the underlying disease than to therapy with novobiocin. Although reports such as the above are rare, discontinuance of novobiocin is indicated if jaundice develops. If continued therapy appears essential because of a serious infection due to microorganisms resistant to other antibacterial agents, liver function tests and blood studies should be performed frequently, and therapy with novobiocin stopped if necessary.

In a certain few patients treated with this agent, a yellow pigment has been found in the plasma. The nature of this pigment has not been defined. There is evidence that it may be a metabolic by-product of novobiocin, since it has been reported to be extractable from the plasma (pH 7 to 8.1) with chloroform while bilirubin is not. These properties have been employed to differentiate the yellow pigment due to the metabolic by-product of novobiocin and bilirubin. However, recent reports indicate that this method of differentiation may be unreliable.

Urticaria and maculopapular dermatitis have been reported in a significant percentage of patients treated with Albamycin. Upon discontinuance of the drug, these skin reactions rapidly disappeared.

Warning: Since Albamycin possesses a significant index of sensitization, appropriate precautions should be taken in administering the drug. If allergic reactions develop during treatment and are not readily controlled by antihistaminic agents, use of the product should be discontinued.

Total and differential blood cell counts should be made routinely during the administration of Albamycin. If new infections appear during therapy, appropriate measures should be taken; constant observation of the patient is essential. If a yellow pigment appears in the plasma, administration of the drug should be continued only in urgent cases, and the patient's condition closely followed by frequent liver function tests. In case of the development of liver dysfunction, therapy with this agent should be stopped.

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DECEMBER, 1961

Woman's Auxiliary

to the

WEST VIRGINIA STATE MEDICAL ASSOCIATION

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KANAWHA

The annual Doctor's Day luncheon of the Woman's Auxiliary to the Kanawha Medical Society was held at the Woman's Club in Charleston on March 28.

Eighty members and guests attended the luncheon, at which time senior members of the medical profession were honored. Included were Dr. A. A. Shawkey, retired after 59 years of practice, and Dr. U. G. McClure, 56 years of service. Also honored were the following physicians who are still actively engaged in practice: Drs. W. W. Point, 49 years; Dr. Morris I. Mendeloff, 48 years; and Dr. Lloyd E. Cox, 39 years.

A skit, "A Day in a Doctor's Office," was directed by Mrs. George Miyakawa.

That evening, members of the Auxiliary honored their husbands at a dinner-dance which was held at the Daniel Boone Hotel. Mrs. Michael Kovacevich was in charge of arrangements for both the luncheon and dinner meetings.—Mrs. Paul Francke, Jr., Press and Publicity.

Mrs. J. Dennis Kugel was elected president of the Woman's Auxiliary to the Kanawha Medical Society at a meeting which was held at the Press Club in Charleston on April 10. Other new officers for the coming year are as follows:

Mrs. Joseph A. Smith, president elect; Mrs. A. A. Abplanalp, first vice president; Mrs. Earl A. McCowen, second vice president; Mrs. William A. Thornhill, Jr., third vice president; Mrs. Olin C. Glass, fourth vice president; Mrs. Kenneth G. MacDonald, treasurer; and Mrs. James B. Nichols, Jr., corresponding secretary.

Mrs. Thornhill presented a monologue, "One Day After," a fictional story of a massive bombing of the United States.

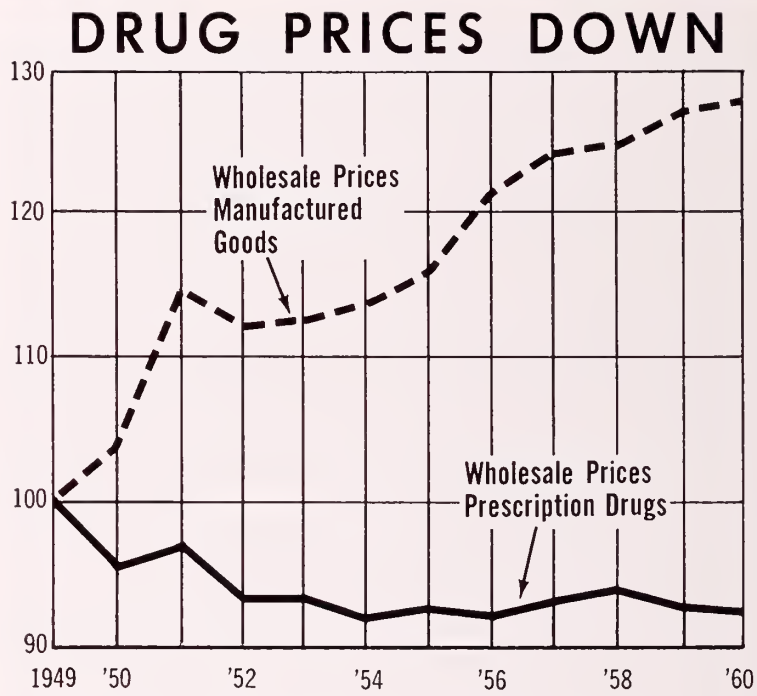
Dr. John A. B. Holt, Chairman of the State Medical Association's Committee on Medical Emergencies and Civil Defense, was an honor guest.—Mrs. James B. Nichols, Jr., Corresponding Secretary.

* * * *

McDOWELL

A Doctor's Day Dinner, sponsored by the Woman's Auxiliary to the McDowell County Medical Society,

The facts on Drug Prices:



Despite ten years of inflation, wholesale prices of prescription drugs have not risen to keep pace with increased manufacturing and distribution costs. This chart compares the wholesale prices of all manufactured goods, up 26.7 percent, with the wholesale price of prescription drugs, down 7.6 percent, during the period 1949-1960.

Source: U.S. Bureau of Labor Statistics, Wholesale Price Index; John M. Firestone, Assoc. Professor, College of the City of New York. Base, 1949 — 100.

Over the past two years, there's been a lot of talk in the press about "the high price of drugs." You've read it yourself—and probably many of your patients have asked about it.

What are the facts?

According to a recent study by Professor John M. Firestone, economist of the City College of New York, manufacturers' prices on ethical drugs actually *declined* 7.6 per cent between 1949 and 1960. (And preliminary 1961 figures indicate a further drop.)

In contrast, the wholesale prices of all manufactured goods rose 26.7 per cent during the same period.

The graph shows this contrast at a glance.

The 12 years it covers marked the introduction of many of the most valuable drugs of the modern armamentarium: the broad-spectrum antibiotics, the steroid hormones and their analogues, the oral diuretics, the ataractics and psychic energizers, and the hypotensive agents.

That so much fruitful research was carried out *while prices were simultaneously being lowered* is one of the least-known, yet most remarkable aspects of the pharmaceutical revolution of our time.

THIS MESSAGE IS BROUGHT TO YOU ON BEHALF OF THE PRODUCERS OF PRESCRIPTION DRUGS.
***PHARMACEUTICAL MANUFACTURERS ASSOCIATION** • 1411 K. STREET, N.W., WASHINGTON, D.C.*

was held at the Cow Shed in Pineville on March 31. The invocation was given by Dr. J. Howard Anderson.

Mrs. H. A. Bracey, the president, presided and welcomed the physicians, and the response was given by Dr. George L. Fischer, president of the Medical Society. Physicians were presented red carnations and Mrs. John S. Cook related the significance of the traditional flower used nationally for this occasion. Each physician was called upon to relate a humorous incident which had occurred during his daily practice.

Mrs. Bracey announced that Mrs. A. B. Carr had been awarded first prize in the poetry competition of the West Virginia State Federation of Womens' Clubs for her poem "Rejuvenation."

Arrangements for the meeting were made by Mesdames Dante Castrodale, R. H. Edwards, F. L. Johnston, A. J. Villani, Charles B. Chapman and George L. Fischer.—Mrs. F. L. Johnston, Secretary.

* * * *

MONONGALIA

Mrs. Vernon L. Dyer of Petersburg was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Monongalia County Medical Society which was held at the Morgantown Golf and Country Club on April 3.

Mrs. Dyer, who is president of the State Auxiliary, spoke on the role of the physician's wife in the home and community, stressing the need for high ideals and enthusiastic living.

Mrs. Charles Turner, president of the Caduceanns, medical students' wives' group, reported on the activities of that organization. Special guests were Mrs. Lysle T. Veach of Petersburg and Mrs. Paul A. Miller of Morgantown.

Mrs. John H. Trotter presided at the business meeting and new officers for the coming year were elected. Hostesses for the dinner meeting were Mesdames J. C. Pickett, Carl E. Johnson, Lucien M. Strawn, C. Ben Pride, Samuel C. Dotson, Jr., and Glenn Ashworth.—Mrs. John J. Lawless, Publicity Chairman.

Responsibility of the Drug Industry

The activities of the universities and their research laboratories and those of the pharmaceutical industry are not competitive but complementary. There is an increasingly broad overlapping of interests. Both do and should have large and effective research programs.

It is the prime function of the one to probe and to teach, and it is in our American system the function of the other to do research with the aim of finding and developing new health-giving aids which will come slowly or not at all if we place our dependence upon the government, or for that matter on universities, either state or private.—Lowell T. Coggeshall, M. D., Vice President, University of Chicago.

People today are using medical goods and services more than they did in years past, partly because they have more education in health matters and partly because higher incomes have raised the standards of what good medical care should be.—Changing Times.

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Book Reviews

MEDICAL MALPRACTICE—Monograph published by Defense Research Institute, P. O. Box 126, University Station, Syracuse, New York. January, 1962. Price 50 cents.

The 45-page content of this publication offers the most competent legal advice as regards medical malpractice the reviewer has ever encountered in such compact form, and with a fee of only fifty cents for such timely advice, no physician can afford its absence from the reading matter kept close at hand.

The members of the Defense Research Institute, and the contributors to its publications, are attorneys, well-qualified by training and experience, in the defense of legal claims against physicians for alleged malpractice. Any physician who heeds their advice will minimize his chances of becoming involved in such embarrassing situations.

As expressed in the monograph, and so often by our late and beloved Charles Lively, "*res ipsa loquitur.*"—James S. Klumpp, M. D.

* * * *

SURGERY OF THE AMBULATORY CHILD—By S. Frank Redo, M. D., Surgeon in charge of Pediatric Surgery, Department of Surgery, The New York Hospital; Associate Attending Surgeon, The New York Hospital; Assistant Professor of Surgery, Cornell University Medical College. Pp. 340, with numerous illustrations. Appleton-Century-Crofts, Inc., 34 West 33rd Street, New York 1, N. Y. 1961.

This is an excellent small book covering the subject of so-called minor surgery, a currently unpopular term, in the pediatric age group. There are some who might think this text redundant but in view of the increasing specialization going on in all phases of medical practice, a text such as this is inevitable. The book was not written for the tyro. The introductory chapters, however, do include basic material. In addition, each chapter has excellently selected references designed to extend information on practically every subject covered in the book.

The author, himself, in his practice points out and suggests the difficulties in differentiating the child who is to be treated on an ambulatory basis from the surgical point of view and the child who must be hospitalized. There is an adequate table of contents and the index is complete. The introductory chapters cover materials, fundamental technique, and special procedures. There is an adequate discussion on anesthesia in the ambulatory child. There are discussions on antitoxins, toxoids, chemotherapy and antibiotics. Soft tissue trauma is then covered quite adequately. There is a short discussion of fractures.

Next, on a regional basis, inflammatory diseases are reviewed. Following this, soft tissue tumors are discussed. Next, burns and bites and stings are reviewed. The final chapter is an excellent and useful one on the care of children with operatively created stomata, such as trachcostomies, esophagostomies, gastrostomies and jejunostomies. In addition, the care of ileostomies and colostomies are described. Urinary tract stomata are also included in this discussion.

I might add that the book does not have many illustrations but those that are included are excellent and pertinent. All in all, the text brings between two covers much material in a concise compact manner for which a reader would have to search quite widely.—Joseph P. Seltzer, M. D.

* * * *

THE ABORTIONIST—By Dr. X as told to Lucy Freeman, New York, New York. Pp. 216. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, New York. 1962. Price $3.95.

This is the story of one man's medical practice, his medical life, who in spite of his journey into "gray medicine" remained a doctor to the very end. Doctor X began his practice during the depression and because of financial necessity drifted into his abortion practice; but as he gained medical skill, financial security and intellectual maturity he continued it as a humanitarian service to mankind.

Realizing that in limiting his practice to an illegal procedure he is building his future security on a flimsy foundation so to compensate for this stigmata, he conducts himself with dignity and circumspection, giving the patients the best surgical care in pleasant surroundings, comforting them with warm and complete understanding and not making the size of the fee the criterion for performing the procedure.

Doctor X gives dozens of examples of situations men and women find themselves in when an unwanted conception takes place, and explains the different methods used to induce an abortion successfully. This is the story of a well-trained physician skilled in one phase of obstetrical pathology, with a fund of knowledge about surgical procedures, infections, antibiotics and blood replacement.

His modern surgical technique includes the services of a qualified operating room nurse and a qualified anesthetist in a modern operating room setup. In spite of the insecurity of this type of practice, Doctor X exhibits a high degree of personal discipline and enjoys the respect of his friends and medical colleagues as well as becoming a patron of the arts.

As Doctor X increases in intellectual stature, he looks upon his practice as a humanitarian service in relieving the population explosion and in offering relief to mothers who are denied a therapeutic abortion by physicians in hospital circles.

He found that in only three states and in the District of Columbia therapeutic abortion is permitted and in the remainder of the states this procedure is performed by circumventing the law. He found that the greater need for abortion was required by mothers with large families, who because of poor health or economic necessity could not bring themselves to carry another pregnancy to full term, which fact has been substantiated by recent articles and on audio tapes that the greatest portion of the population seeking relief from pregnancy are the medically indigent, the mentally incompetent, the physically overworked and the maladjusted to medical and economic stresses. He quotes the work of Guttmacher and Sophia Kleegman to good advantage.

Justice MacNaughton of the English supreme court

gives several pertinent opinions concerning performing therapeutic abortions: "The law is not that the doctor has got to wait until the unfortunate woman is in peril of immediate death and then at the last moment snatch her from the jaws of death. He is not only entitled, but it is his duty, to perform the operation with a view to saving her life." ". . . if the life of the woman could be saved by performing the operation and the doctor refused to perform it because of some religious opinion, and the woman died, he would be in grave peril of being brought before this court on a charge of manslaughter by negligence."

The career of Doctor X is interrupted by an arrest, trial and prison term. He finds out that no matter how successful one becomes and no matter how much you help people out of serious trouble, if your income is based on shady sources then people turn on you with a vengence.

The prison term led to introspection, self-analysis and finally to psychoanalysis. He discovers his antagonism to the law stems from childhood traumata from an overbearing mother. He realizes he must discontinue performing abortions but he feels he must continue, not only because of financial necessity, but because his skill is necessary to preserve the lives of the many mothers seeking relief from unwanted pregnancies.—Frederick H. Dobbs, M. D.

Weight Control: A Physician's Job

If we doctors don't do the job, everybody and his brother is going to get in on the act of controlling obesity. This is clearly a physician's responsibility. Indeed, it overlaps several well recognized medical specialties: gastroenterology, gynecology, endocrinology, internal medicine, metabolism, pediatrics, pathology, and psychiatry—to name a few. For some reason, many clinicians have hesitated to do serious work in this field. Into the resulting vacuum have come a host of diet faddists, physical culturists, cosmetologists, gymnasts, dance instructors, masseurs, nonmedical nutritionists and a spectrum of crackpots promoting a variety of fancies.

Yet this is a medical specialty worthy of any physician's interest and challenge. The problem is obviously a big one. The practitioner willing to devote time to the study of nutrition and the control of overweight will find his patients grateful, the results visible, and himself a pioneer in what may well become a new medical specialty. Perhaps it will be called steriatrics, from the Greek for "physician to the fat." (If there isn't such a word now, there ought to be; and it sounds as if it really belongs to the parade of medical specialties: we have pediatrics and ephebiatrics and geriatrics; why not steriatrics?)

As a specialty it has some real advantages. There should be no night calls or emergencies; none of the steriatrist's patients should die. The doctor will find himself involved in many branches of medicine. He will have to learn a lot about the human body. He cannot learn it in ten easy lessons, since he will have to acquire some grasp on biochemistry, metabolism and endocrinology, as well as applied psychology. He will have an opportunity to develop group psychotherapy, for food addiction, like alcohol addiction, is handled well in groups. Misery loves company, and each victim reassures and challenges the other.

Some clinicians look down their noses at steriatrics. They see it as a kind of cosmetology, unworthy of the physician's attention. This is an unfortunate and unjustified snobbery. The obese person belongs in a doctor's office. Let us not drive him to the cultist by assuming that it is *infra dig* for the physician to treat this problem. It isn't. On the contrary, a well-rounded patient will develop a well-rounded doctor.

Obesity is rapidly becoming a major health problem. An accolade is due the physicians who realize that it is their responsibility to tackle it.—The Journal of the Medical Society of New Jersey.

Reducing the Toll

Accidents continue to rank fourth among the leading causes of death in the United States. But their decreased rate—or the decline in number of accidents per every 100,000 population—is heartening evidence of our ability to organize public effort, particularly in an era of tremendous population growth.

The current death rate from accidents is only half the peak rate in 1906 when our society was far less mechanized and our people far less mobile. The National Safety Council, the National Fire Protection Association, the American Red Cross and numerous other voluntary and governmental associations and agencies, as well as large industries, have done an outstanding job in developing accident consciousness and in creating safer working, home, and recreational environments.

The National Health Forum meeting in Cleveland in March of this year has as its theme, "Accident Prevention and Emergency Care." Five hundred experts will assemble under the aegis of the National Health Council and its 70 member agencies. In this way, the Council contributes to stimulating informed action to insure further progress in accident prevention.

Beyond any question, it is through such preventive action and through education that the record of fatal and injurious accidents can be improved. In spite of what seems to be phenomenal progress, there were an estimated 91,000 fatal accidents last year, and 9½ million disabling injuries that cost an incalculable amount of discomfort, much of it permanent; time lost from work; and need for medical attention. It is estimated that accidents cost the American public about $13.5 billion in 1960.

As the statistics in this bulletin show, the greatest opportunity for further progress rests on more public education to prevent accidents in the home. This is the area in which we have achieved the least, where safety depends on the individual's foresightedness to protect himself. Obviously, such accidents, so frequently preventable, so often tragically fatal, can be reduced in number only as safety-consciousness is emphasized continually to our entire population.—George Bugbee, President, Health Information Foundation.

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JUNE
1962

Vol. 58 No. 6

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 343-4607.

Member 1962

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The West Virginia Medical Journal

June, 1962 Vol. 58, No. 6

Practical Approach to Mold Allergy*

Homer E. Prince, M. D., and Marie Betzner Morrow, Ph. D.

Following the pioneer reports by Van Leeuwen[7] and Cadham,[4] in 1924, there has been increasing appreciation of the allergenic role of air-borne molds. Correlation of clinical and atmospheric survey data now offers etiological explanation of many previously obscure cases of respiratory allergic disease on the basis of inhalant mold sensitization. The more important molds have been determined for most areas and for some special environments and, in some instances, their significant variation may be predicted with a fair degree of accuracy.

The complexity of the mold problem frequently has been a discouraging factor, however, and only too often has led to compromises, particularly in the selection of adequate diagnostic and therapeutic fungous allergens. A review of the sources, essential factors affecting growth and dissemination, and the geographic distribution of the common air-borne molds will simplify the clinical aspect of mold allergy.

Sources and Distribution of Molds

Molds are widely distributed in nature, and their primary habitat is the soil. They grow on many species of vegetation, occasionally in a pathogenic but more frequently in a saprophytic, capacity. Especially are molds likely to flourish on plant residues, and in this relationship they appear to have a selective affinity for certain plant species. This is a matter of great importance in determining mold populations in some agricultural areas. An example is found in the increased atmospheric concentration of Alternaria spores in the grain belt after harvest season, when the cutover stubble furnishes an ideal substrate for this genus. Many genera and species of molds actually participate in this process, which goes on continuously in variable degree throughout the entire plant kingdom as a part of the catabolic cycle by which plant residues are returned to the soil. It is thus understandable that the soil is the ultimate reservoir of viable mold spores where, under proper conditions, further proliferation may be expected to occur.

From these inexhaustible natural sources molds find their way indoors. Here they may grow, possibly selectively, on fabrics, upholstery material, bedding, leather articles, wall paper, fruits and vegetables, or even boards and building timbers. Molds ordinarily grow more abundantly indoors in periods of high humidity. They may be especially troublesome at any time in damp cellars or poorly ventilated basements or subfloor areas. Stored agricultural products such as hay or feed grains may pose particular problems for farm workers. High mold concentrations frequently are encountered in seed and cereal mills and in grain storage elevators. Exhausts from these sources are known to contaminate large areas of the surrounding countryside.[18]

It thus is obvious that molds may be encountered through general atmospheric contamination as well as in local or particular environments. The point of importance, however, is that the molds generally regarded as "soil forms" which make up most of the ordinary atmospheric totals are those with which we are primarily concerned,

The Authors

- **Homer E. Prince, M. D., Crockett, Texas, Professor of Clinical Medicine (Emeritus), Baylor University College of Medicine. Now located at 1310 Austin Avenue, Waco, Texas.**
- **Marie Betzner Morrow, Ph. D., Associate Professor of Microbiology, Department of Bacteriology, University of Texas, Austin, Texas.**

*Presented by Doctor Prince before the annual meeting of the West Virginia State Society of Allergy, held during the 94th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24, 1961.

exeept in oeeasional and exceptional environmental situations.

Factors Affecting Mold Growth and Dissemination

The critieal minimum of moisture necessary for growth of many speeies of molds appears to be surprisingly low. This was seen in the early survey studies of the Assoeiation of Allergists for Myeological Investigations[8] which revealed some of the highest mold eounts in relatively dry regions, indieating that there is sufficient moisture in many dry areas for periodie growth of molds, and subsequent air dissemination.

Variation in the atmospheric mold load seems to reflect general seasonal and geographic influences. Of these, temperature doubtless is the most important; its effect is strikingly seen in the low counts of air-borne molds in the North in winter. Also, there may be an upper limit of optimal temperature above which growth of some molds diminishes, as indicated by lowered eounts of Hormodendrum in the South in the summer, although the average southern temperature in winter seems to favor abundant growth of Hormodendrum. Snow blankets over large areas may add a meehanical factor to retard mold spore dissemination. Distribution of plant species doubtless eontributes to the geographie pattern of air-borne mold populations.

Meteorologieal factors exert profound effects on loeal fluctuations of molds in the air. Thus, in periods of varying humidity molds may or may not beeome readily air-borne, and counts will vary, even when actual growth is most active. These relationships often are disregarded or eonfused by statements eorrelating high mold counts and "damp weather," without taking into eonsideration all of the factors involved.

We have called attention previously to the "post-frost" effect on counts of air-borne molds.[13] This is typically manifested during a period of dry weather beginning some days after the first heavy frost, when conditions are ideal for air dissemination of spores produced by the ineeased saprophytic activity of molds on the devitalized vegetation. The post-frost effeet may produce overwhelming mold eounts in blustery weather.

Geographic Distribution and Seasonal Incidence

Results from survey studies have revealed certain general distribution patterns, based on the occurrence of dominant forms of molds most frequently encountered in the United States. These studies emphasize the seasonal, geographic and bioclimatological influences which determine mold occurrence and variations over broad seetions or under certain conditions within more limited areas. The information derived from survey studies affords a practical working basis and is surprisingly eonsistent for eertain regions studied over long periods.

Our findings revealed the following:[8]

1. Alternaria is encountered more frequently than any other genus in most areas. It occurs perennially in the South, but in the North its numbers are greatly reduced in winter, with increasing eounts in late spring and summer to peak levels in mid-autumn. Alternaria eounts are eonspicuously low in the Pacifie Northwest.

2. Hormodendrum is encountered next to Alternaria in numbers, and is found in all areas. In the North, Hormodendrum occurs regularly except in winter, with peak eounts in late spring and fall. In the South, Hormodendrum counts are highest from fall to spring, with reduction in the warmer months. High total mold counts for most areas, and low counts in the North in the winter, reflect variations of Alternaria and Hormodendrum. Seasonal factors are suggested for both of these genera.

3. Helminthosporium and Spondylocladium occur in the North in summer and in the South from spring to fall, but the counts for both are lower than for Alternaria and Hormodendrum. Seasonal factors are suggested.

4. Pullularia oeeurs with some regularity, but occasionally in greatly increased numbers or "showers." This eould be a result of environmental faetors.

5. Aspergillus and Penicillium as well as other moniliaceous genera appear to be widespread, but counts are usually low. These forms doubtless depend more on local environment than on seasonal or geographic factors.

6. Fusarium is widely distributed, but counts usually are low. It is encountered more often in the South, suggesting seasonal influences.

7. Phoma, Chaetomium and species of Mucorales, represented by Rhizopus and Mucor, occur irregularly with low eounts without apparent seasonal or geographic trends.

Data summarized as above may be useful in approximating the significant molds anticipated in one's area of practice. Until the physician is thoroughly familiar with the mold problem, however, he will do well to augment this information with his own survey studies for further details of local mold occurrences. Such studies may reveal significant mold concentrations and seasonal variations of an environmental nature resulting from agricultural, industrial or other sources in special areas. An example was the increased Helmin-

thosporium counts in South Texas several years ago after flax was introduced as an agricultural crop. Local mold surveys should prove very valuable in establishing the actual variations resulting from the meteorological patterns characteristic of the particular area. Environmental studies for determining the mold flora in homes or places of work frequently are necessary for successful clinical handling of patients with particular diagnostic problems.

Mold surveys may be made by microscopic examination of the spores and mold fragments which appear on ordinary adhesive pollen slides (Figure 1). The usefulness of this method, however, is limited because relatively few molds are recognizable on pollen slides. Outside exposure of culture plates containing a medium selective for mold growth is preferable, although this procedure is time-consuming and may require collaboration of a mycologist. By the plate method a seasonal picture can be obtained for a given location and, once established, is useful for comparison with subsequent plate studies which are recommended.

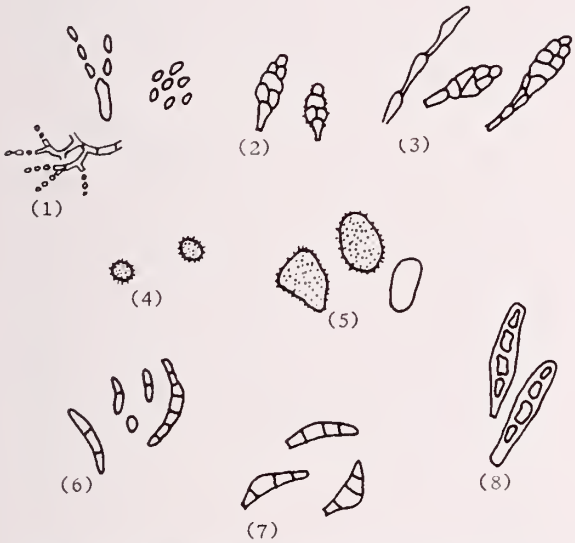

Figure 1. Sketches of mold spores ordinarily identifiable on pollen slides. Approximate spore size in microns: (1) Hormodendrum 3-6 x 2-3; (2) Stemphylium 25-40 x 16-20; (3) Alternaria 30-36 x 14-15; (4) Smut 8-11 x 5-9; (5) Rust 13-21 x 23-26; (6) Fusarium 12-29 x 3-4; (7) Spondylocladium 25-30 x 12-15; and (8) Helminthosporium 22-26 x 9-11.

Clinical Considerations: Diagnosis

Except for environmental or seasonal association, symptoms in all age groups are not characteristic for mold allergy. Inhalant fungous allergens, therefore, may cause both nasal and bronchial symptoms and, occasionally, allergic eczema. Seasonal symptoms occurring between the spring and fall pollen seasons are suggestive of mold allergy in northern latitudes but in the South symptoms more often are perennial or erratic. Correlation of symptoms with particular environmental exposure occasionally suggests mold sensitization. We remember a farmer's wife who had symptoms regularly when she was in the proximity of a certain field, or when she contacted hay which had been produced in this field; she was found to be sensitive to several species of Penicillium. Increased symptoms of respiratory allergy immediately after frost (the post-frost effect) are very suggestive of sensitization to air-borne molds.

Definite diagnosis must depend on positive reactions to reliable mold extracts. Skin tests with mold allergens are performed according to established techniques for testing with any other highly allergenic extracts. We use the term "highly allergenic" advisedly, first, because if mold extracts do not possess this quality they are useless and, second, to imply the respect with which presently available mold extracts must be regarded.

For the past two years we have employed MMP extracts*[12] exclusively for skin testing. Preliminary scratch (pressure puncture or punch) tests are made with the 1:100 glycerosaline concentrates. Positive reactions may be confirmed with intradermal tests, in beginning dilutions of 1:100,000 or, for more sensitive patients, 1:1,000,000. In performing intradermal tests on highly sensitive patients, using these extracts, it is advisable not to employ several closely related genera simultaneously, particularly of the dematiaceous family, for fear of producing systemic reactions. If preliminary punch tests are negative, intradermal exclusion tests may be made with 1:10,000 aqueous dilutions. With these highly reactive mold extracts we ordinarily find the scratch (punch) tests to be diagnostic, and perform intradermal tests for "titration" purposes or to detect lesser degrees of cross sensitivity which might exist in botanically related molds.

For several years we have employed extracts of those molds listed in Table 1 in routine tests for the diagnosis of mold allergy. This representative list is based on mold occurrence in survey studies at stations in Central and Southern United States.[8] For reasons presently to be discussed, it is imperative that multiple genera, or even several species of some genera (in the Moniliaceae) be included in the diagnostic allergens. Restriction of the list to only a few, for example, Alternaria and Hormodendrum, because these are the most commonly encountered or may react more frequently, and a species or two of Penicillium and Aspergillus, may result in failure

*Available from Hollister-Stier Laboratory, Spokane, Washington.

to discover or evaluate properly many cases of mold sensitivity.

TABLE 1

Molds Arranged in Botanical Groupings for Skin Testing

PHYCOMYCETES
Rhizopus nigricans
Mucor Racemosus

FUNGI IMPERFECTI
Dematiaceae
Alternaria tenuis
Curvularia spicifera
Spondylocladium sp.
Helminthosporium interseminatum
Hormodendrum cladosporioides
Stemphylium botryosum
Nigrospora sphaerica
Pullularia pullulans

Moniliaceae
Aspergillus fumigatus
Aspergillus flavus
Aspergillus glaucus
Aspergillus nidulans
Aspergillus niger
Aspergillus sydowi
Aspergillus terreus

Botrytis cinerea

Gliocladium fimbriatum

Moniliaceae—ctd
Monilia sitophila

Mycogone nigra

Paecilomyces varioti

Penicillium atramentosum
Penicillium biforme
Penicillium intricatum
Penicillium carmino-violaceum
Penicillium luteum
Penicillium notatum

Trichoderma viride

Sphaerioidaceae
Phoma herbarum

Tuberculariaceae
Fusarium vasinfectum

ASCOMYCETES

Saccharomycetaceae
Saccharomyces cerevisiae

Torulaceae
Rhodotorula sp.

Chaetomiaceae
Chaetomium sp.

Multiple reactions to tests with molds may be very confusing. In fact, failure to take advantage of the information to be gained from such reactions is responsible for much of the complexity of the mold problem for allergists. The secret of meaningful evaluation of multiple reactions lies in the fact that immunological reactivity among the molds frequently is determined by botanical classification. Viewed in this light, reactions of closely related mold genera become mutually confirmatory, thereby defining significant reaction groups which may extend to include several or all of the genera in entire botanical families.

Conspicuous group reactions occur with greatest regularity among genera of the most important of the mold families, the Dematiaceae. A reaction to one species representing a genus, such as the genus Alternaria in this family, frequently is associated with reactions to species of one or more of the other genera. On the other hand, only one species may react, and this isolated reaction usually is to a species of Alternaria. Occasionally, Alternaria will be the only mold, not only of the dematiaceous family but of the entire list, to react. Because of its high allergenicity, Alternaria frequently has been selected as a representative allergen for the entire dematiaceous family. Experimental clinical studies[11] several years ago and, more recently, immunological experiments,[2] however, suggested that while genera of the dematiaceous group may contain common family allergens, additional generic allergens also may exist. It seems more logical, therefore, to attach significance to all reacting species or genera rather than to consider Alternaria as a "key" genus for the entire Dematiaceae. This reasoning is readily extended to multiple reactions in other groups.

Several years ago we combined species or generic allergens of related mold groups into appropriate testing mixtures. Although these mixtures gave diagnostic reactions, we discarded them for the more confirmatory evidence obtainable from their botanically related constituents. Such mixtures may be employed for screening purposes.

Relative Incidence of Reactions to Various Molds

In 1959, we reported the number of reactions to air-borne molds in 68 mold-sensitive children on the basis of tests with acetone precipitated (Type 33) extracts.[13] These children were from the Houston, Texas, area, and the group included a few from a radius of approximately 200 miles. Although reactions in adults were not included in the series, there are no essential differences in either age group. The reactions, therefore, can be accepted as representative for the Southeast Texas area. Table 2 shows the reactions to molds

TABLE 2

Reacting Molds in 68 Mold Sensitive Children

	Number of Reactions	*Per Cent*
PHYCOMYCETES		
Rhizopus nigricans	9	13
Mucor racemosus	8	12
FUNGI IMPERFECTI		
Dematiaceae		
Alternaria tenuis	66	97
Curvularia spicifera	45	66
Spondylocladium sp.	44	65
Helminthosporium interseminatum	23	34
Hormodendrum cladosporioides	26	38
Stemphylium botryosum	49	72
Nigrospora sphaerica	17	25
Pullularia pullulans	33	48
Moniliaceae		
Aspergillus fumigatus	7	10
Aspergillus flavus	4	6
Aspergillus glaucus	4	6
Aspergillus nidulans	2	3
Aspergillus niger	5	7
Aspergillus sydowi	2	3
Aspergillus terreus	4	6
Botrytis cinerea	6	9
Monilia sitophila	8	12
Mycogone nigra	11	16
Paecilomyces varioti	9	13
Penicillium atramentosum	7	10
Penicillium biforme	10	15
Penicillium intricatum	4	6
Penicillium carmino-violaceum	10	15
Penicillium luteum	7	10
Penicillium notatum	7	10
Trichoderma viride	5	7
Sphaerioidaceae		
Phoma herbarum	53	78
Tuberculariaceae		
Fusarium vasinfectum	11	16

encountered in the 68 children. The preponderance of reactions to dematiaceous genera over all the other molds except Phoma is clearly indicated. Within this family, the order of reactions was as follows: Alternaria, Stemphylium, Curvularia, Spondylocladium, Pullularia, Hormodendrum, Helminthosporium and Nigrospora.

The number of reactions to Phoma is of particular interest. For several years we have noticed that patients sensitive to Alternaria frequently react also to Phoma. While ordinarily we have not employed Phoma therapeutically, we test with it routinely for confirmation of reactions to Alternaria. There is experimental evidence of close botanical relationship between Alternaria and Phoma.[1, 9, 3]

Incidence of Mold Sensitization

Reports by various authors are not in agreement concerning the relative incidence of mold sensitization in comparison with other inhalant allergens. Much of the published data reflects skin test reactions only, with incidences of positive reactions to molds of 69 per cent,[17] "a large percentage,"[10] and "less than 10 percent."[15] Feinberg[5] estimated that 20 per cent of allergic persons are sensitive to fungi, while Hyde and his colleagues[6] suggested upwards of 5 per cent. All reports stress the complexity of the problem, in view of commonly coexisting sensitizations to other allergens as well as molds.

In a series of 108 allergic children, our findings, reported in 1959 (op. cit.), revealed that 101 (93 per cent) and 27 (26 per cent), respectively, were clinically sensitive to dust and pollen, while 23 (21 per cent) were regarded as clinically sensitive to molds. Seven more of the patients in this series reacted to molds by skin tests, but were not treated with molds, in keeping with our policy of conservatism in evaluating mold reactions.

In another group of 180 allergic patients currently receiving injection treatment with mold and other inhalant allergens, 53 (or 29 per cent) are sensitive to molds. All except 6 of these patients reside within a radius of 150 miles of Crockett, in East Texas. The relative frequency of reactions to molds is almost one and one-half times that of our earlier series. This could reflect a higher mold incidence in East Texas than in the Houston area; the preponderance of forest land in East Texas could be significant. On the other hand, patients in the recent group were tested with the more diagnostic MMP mold allergens.

Selection of Molds for Therapy

Mixtures of mold allergens for injection treatment should be as polyvalent as they can be made, in the sense that they include all significant reacting molds within botanical groupings. In order to preserve proper balance in mold mixtures, botanical categories must be observed strictly. For example, all genera of dematiaceous molds producing definite reactions would be included in a dematiaceous mixture. Similarly, if reactions to several genera of the Moniliaceae suggest moniliaceous family sensitization, the reacting species would be combined. Occasionally, the reactions are even more sharply confined to several species of a genus, such as the genus Penicillium or the genus Aspergillus, suggesting an Aspergillus or a Penicillium mixture.

Polyvalent mold mixtures including all closely related species or genera which give significant reactions should be maintained separately from other unrelated but similarly constituted mixtures until dosage for each is stabilized; thereafter, the mold mixtures may be combined for convenience.

Treatment With Molds

Conventional injection treatment with mold extracts is carried out in keeping with commonly accepted principles which apply to injections of any allergens in respect to beginning concentration, dosage increments, and interval between injections. A few unusual circumstances, however, may pose special problems in treatment with mold allergens. The first of these is that treatment with molds frequently must be carried out on a co-seasonal basis in areas in which seasons are long, or in which molds occur perennially; particularly is this true in the South. Also, unpredictable increase in atmospheric mold concentrations resulting from meteorological caprice may adversely affect sensitive patients before appropriate dosage revision can become effective. Systemic reactions occur occasionally when near ceiling dosage injections coincide with sudden increase in atmospheric mold loads before the latter are detected. Finally, the frequent coexistence of sensitizations to house dust and pollens adds greatly to the complexity of specific treatment with molds. Perennial treatment is preferable for patients with multiple sensitizations which include molds, and it is mandatory in areas of long and overlapping pollen and mold seasons.

"Top dosage" or "ordinarily protective dosage" varies widely for mold extracts as it does for any other allergens. In the case of acetone precipitated extracts, many patients do well on dosage of about 0.25 ml. of 1:1,000 dilution. We can recall several children, however, who could tolerate no more than 0.30 to 0.50 ml. of 1:50,000.

Our observation regarding dosage requirements and tolerance of the newer MMP mold al-

lergens in conventional injections is limited to 28 transition patients who were maintained at protective or subceiling dosage levels for periods of a few weeks to several months before their treatment was changed from multiple injections of aqueous extracts to single injections of emulsified mold allergens. This group included some patients who had been on acetone precipitated extracts previously; all showed excellent clinical response to injections of the MMP allergens. Only 8 of these patients attained the dosage we had come to accept as ideal (if it could be reached) with formerly employed acetone precipitated extracts. The multiple injection dosages for the 28 patients are revealed in Table 3.

TABLE 3

Protective Dosage For 28 Patients Treated With Conventional Injections of MMP Mold Allergens

Number of Patients	*Age Group* *Child*	*Adult*	*Dosage*	*Concentration*
1	X		0.30	1:1,000
4		X	0.25	1:1,000*
3	X			
3		X	0.20	1:1,000
5	X			
4	X		0.15	1:1,000
3	X		0.10	1:1,000
1	X		0.15	1:2,000
1		X	0.10	1:2,500
1	X		0.30	1:10,000
1	X		0.25	1:10,000
1	X		0.50	1:50,000

*Two children, one adult occasionally experienced systemic reactions at this dosage.

The new method of treatment by the injection of emulsified allergens is applicable to therapy with molds. In our experience, the single or repository injections have produced more spectacular response with molds than with any other allergens. This is true particularly in respect to longer duration of relief, in comparison, for example, with that obtained from repository injections of house dust, the only other strictly perennial allergen besides molds in our area. All of our aqueous mixtures for emulsions are formulated with MMP extracts in keeping with significant reactions within botanical groups. Our highest dosage has been 0.25 ml. of 1:500 dilution, in terms of the aqueous phase or, roughly, 2500 protein nitrogen units.

Mold Avoidance

In view of the widespread distribution of molds, complete avoidance is impossible, but some general precautions are worthwhile and frequently will enhance the outcome of specific injection treatment.

Standard measures for minimizing house dust contacts, directed to upholstery, rugs, draperies and bedding materials and including frequent and thorough vacuum cleaning, are helpful against indoor molds.

In areas of high humidity, constant effort is necessary to prevent gloves, shoes, leather suitcases and clothing from becoming molded in storage closets. A 50 to 75 watt incandescent electric light bulb kept burning in a closed closet will sometimes keep the area sufficiently dry to minimize mold growth. Brisk mechanical scrubbing of molded articles, followed by wiping with a weak solution of formalin, may be tried. Luggage and other articles which tend to become molded frequently may well be exposed to direct sunlight periodically. In more difficult problems, Schaffer[14] recommends fumigation with concentrated formalin solution in open, shallow vessels. Such treatment may be applied to a closet, a room, or an entire house, the treatment area being closed off during the process.

Mechanical air conditioning affords a practical method of reducing indoor mold growth through lowered humidity. Air conditioning equipment must be installed with care that all refrigerant and water discharge lines are properly insulated to prevent dampness from condensation of atmospheric moisture. The evaporator type air coolers are to be avoided in the homes of mold-sensitive patients, because they frequently become heavily contaminated with molds.[16]

Mold-sensitive persons should avoid grain harvesting or grain handling operations and contact with hay stacks and feed barns. Avoidance occasionally must be directed to entire agricultural areas, especially after grain harvest season, until the stubble has been plowed under. Prolonged outside exposure for several days after frost may be especially hazardous in dry, windy weather.

Summary

Molds occur widely in nature, and their distribution and variation in air populations follow broad general patterns determined both by seasonal and geographic factors. An appreciation of the dominant air-borne molds for any area, together with their seasonal variations, is a prerequisite for handling problems of clinical mold allergy. A further consideration necessary for interpretation of skin tests with mold extracts and the selection of mold allergens for injection treatment involves the immuno-botanical relationship exhibited by fungous allergens.

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The Physician's Responsibility

With the growing interest in Geriatrics, there has developed a renewed optimism about the medical care of the aged. Surgery is now being done with ease, which had been previously thought to be impossible, and has added years of comfort to many of our older patients. The improved outlook toward the psychiatric care of the mentally disturbed elderly patient is most gratifying and has prevented the final commitment of many so-called senile patients to state mental hospitals. Then, too, the efforts at rehabilitation of patients with chronic disabling illnesses have proved that our previous attitude of pessimism is no longer justified in those patients with a reasonably good potential. It is this type of knowledge that the community wants, and the physician is the logical person to disseminate this information.

In our efforts to help the older person adjust himself to the process of growing older, it is more and more apparent to some of us that some type of work is the key to a successful retirement. There are those people who seem to enjoy doing nothing, but they are certainly in the minority. Most of us need a sense of continued usefulness and an opportunity to work, if we want to. To that end, if some type of part-time work could be developed by the community for those people who want it, I am sure that some of the many illnesses growing out of loneliness, idleness, and boredom would be postponed at least until such a time when real physical disability prevented any meaningful activity.

Work is an important aid in maintaining one's self-esteem and a sense of real value to the community. When these are lost, certain psychologic changes develop in the personality of the individual that we recognize as typical of the confused and senile patient. We must make an effort, therefore, to keep the older person active in the life and work of the community as long as possible. Here, again, it is the duty of the physician to inform the community of the urgent need of providing some type of work program for its older members. There is no substitute for useful activity.—A. Hazen Price, M. D., in Journal of the Michigan State Medical Society.

Atopic Dermatitis*

Philip Blank, M. D.

Atopic dermatitis is a disease with an allergic connotation and an argumentative platform. There is no disease in the fields of allergy, pediatrics, dermatology or psychiatry about which so many diverse opinions have been expressed. Baer[1] aptly expressed it by saying, "Atopic dermatitis is not only one of the more common dermatoses but also one about which a lively argument always can be precipitated at the slightest provocation."

The purpose of this paper is not to further these arguments, but to present our experiences with the allergic management of this condition.

Besnier first described the lesion as eczematous lichenification which he called "prurigo diathesis," with itching as its main symptoms. Other observers gave names to the condition that were purely descriptive in a morphological sense or had unproved or false etiological connotations. Brocq,[2] in 1896 and, later, in 1919, created the concept of neurodermatitis. He divided the condition into two forms, i. e., localized and disseminated neurodermatitis, the latter being the atopic dermatitis now under discussion. The following features were considered pathognomonic: nervousness, constant itching, sharp demarcation of the placques precisely limited to the area of the itching, skin changes arranged in concentric zones resembling other dermatoses of nervous origin, dryness of the lesion, hypertrophy of the papillae of the cutis, and chronicity. Brocq's concept primarily was that of neurology, not psychiatry. Other names such as Bedow, Yadison, Sultzberger, Rose and Cocoa enter into the history of the disease. Cocoa and Sultzberger developed the name and concept of atopic dermatitis.

Our impression is that the condition primarily is an allergic disease and can be defined as a dermatosis produced as a result of antigen antibody reaction having the skin as a shock organ. The word "skin" is used advisedly. The condition is characterized by recurring acute and chronic stages in individuals having atopic stigmata. While it is true that many secondary factors are involved, it is our ardent belief that allergy is the primary etiological factor, all others mentioned by various observers being purely secondary.

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Disease Phases

Phases of atopic dermatitis produce various clinical pictures and are as follows:

1. Atopic erythema.
2. Infantile atopic dermatitis.
3. Juvenile atopic dermatitis.
4. Adult type of atopic dermatitis.

Atopic erythema is characterized by redness of the skin, usually that of the cheeks. At this stage the appearance of the skin is not diagnostic of atopy. As a rule, there is a history of a flare of the skin in this area after the ingestion of food. The lesion is evanescent—it appears and leaves quickly. Many pediatricians recognize it and frequently change foods or environmental factors. Their attempts often are successful and as a result these cases seldom are seen by the allergist or dermatologist.

Infantile atopic dermatitis presents papulovesicular lesions with crusting and weeping. They occur on the cheeks but soon extend to the outer aspects of the legs, forearms, wrists and foreheads. Scratching and rubbing may give rise to a punctate appearance. The lesion may become generalized. If so, it may be complicated by erythrodermia, a generalized redness with generalized lymphadenopathy. A striking feature is the coldness and blueness of the hands. There are extreme leukocytosis and eosinophilia, a complication probably due to seborrhea and infection by Staphylococcus aureus. It occurs most frequently in this phase but can be found occasionally in juvenile and adult phases. It is markedly resistant to therapy. The age group is six weeks to two or three years.

The dermatological picture in the juvenile phase is characterized by papulation rather than vesiculation. The common sites are the antecubital and popliteal spaces, wrists, neck, shoulders and face.

*Presented before the annual meeting of the West Virginia State Society of Allergy, held during the 94th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 24, 1961.

In the adult type of atopic dermatitis, the skin is thick, dry and usually erythematous or hyperpigmented with a brownish gray color. The sites involved are similar to those of the preceding phase. The lesions almost always are intensely pruritic. Atopy is not the sole cause of the morphological changes. Scratching, rubbing and other traumatization contribute greatly to the many changes seen in the average case.

Histology

The histological picture varies with the type, although before we attempt to describe the histology, it must be remembered there is no pathognomonic histology connected with this disease.

In the early phase of infantile atopic dermatitis, the histology is that of intercellular and intracellular edema with lymphocytic, eosinophilic and neutrophilic infiltration. The basal cell layer of the malpighian zone can be disrupted by the edema. The epidermis shows some moderate edema with lymphocytic and some neutrophilic infiltration. This is the picture of any acute, nonspecific dermatitis.

In the juvenile type the vesicles and edema are present to a lesser degree. Moderate acanthosis and parakeratosis often are present and the derma shows perivascular inflammatory infiltration mainly composed of neutrophiles and eosinophiles.

In the adult type of atopic dermatitis no vesicle formation is present, but marked acanthosis, hyperkeratosis and parakeratosis can be seen. The edema is minimal, if present at all. The lymphocytes are seen but no neutrophiles are noted in the epidermis. In the two last mentioned phases of the disease, acute changes may occur. Again, these are the typical changes of acute, nonspecific dermatitis.

Clinical History

The clinical history is more interesting than the histology. The earliest signs of atopic dermatitis are itching or erythema, or both. In a young child anywhere from six weeks to two or three years of age, red areas of the cheeks and sometimes of the chin develop. These areas are, simply, erythema, and disappear as quickly as they came. The next stage is mild papulovesicular dermatitis occuring primarily on the face, neck, arms and legs, with weeping and crusting. One thing to be noted is the lack of involvement of the nasal labial folds in contradistinction to seborrhea. The area involving the tip of the nose and the area around the mouth are remarkably free of dermatitis. In fact, during the activity of the disease, these areas appear whiter than usual. This stage, again, is recurrent, may flare in a matter of minutes or hours, disappear quickly, and is characterized by, shall we say, paroxysms of dermatitis.

As a child grows older, the rash changes in appearance. It becomes dryer and more scaly, with perhaps more itching, or is it that the infant is unable to tell us that the itching is so intense? The lesions here, however, assume another distribution. They involve the areas noted in the infantile eczema but also begin to invade the antecubital and popliteal fossae. These may be quite characteristic although the face, wrists and neck also are involved. It must be remembered that these phases overlap.

In the adolescent and adult phases, the lesion no longer shows vesicular changes. The skin becomes thickened, usually is supra-imposed by scratch marks, and the areas are confined to the popliteal and antecubital spaces, the neck, and the face. In the more severe cases, the wrists, hands, feet, upper part of the chest, and shoulders may be involved. In the adult stage there is less tendency to fast coming and going. The disease is much more persistent as age increases, and the lesions become more difficult to reverse.

Associated Characteristics

The lesions of atopic dermatitis are accompanied by associated characteristic stigmata which include a tendency to white dermagraphism, abnormal responses to heat, cold and other stress, lower than normal resistance to skin infections with viruses such as those of vaccinia and herpes simplex, and perhaps a greater than normal resistance to pyodermic infections and to contact type allergic eczematous dermatitis. Sudden, shock-like, sometimes fatal, reactions may occur on exposure to foreign agents such as foreign sera and medicaments.

Other characteristics are loss of hair of the eyebrows from continuous rubbing, scaliness of the skin around the eyes, and a deep line on the lower lid. Occasionally, certain forms of juvenile cataract may be noted. All other stigmata of allergy such as asthma, hay fever and urticaria also can be observed in these cases. Hyperpigmentation and depigmentation may be seen on healing. The areas involved frequently do not tan to sunlight.

Complications

Complications are few and consist primarily of infection, lichenification and fibrosis of the skin. The most severe complication is infection with viruses such as vaccinia and herpes, sometimes to the extent of a fatal outcome. It is extremely dangerous to vaccinate a child with active atopic dermatitis unless the lesions are completely cleared. Although suppurative types of bacterial

infections are rather rare, nonsuppurative types are not too uncommon, especially in the condition's more acute phases. It is not uncommon in the less chronic phases to see a relatively nonpathogenic staphylococcus causing rather distinct irritation of the condition. If there has been a good deal of infection or trauma of the skin, with marked inflammatory changes, there will result a varying amount of healing by fibrosis, thus permanently changing the characteristics of the skin.

An uncommon but not an unusual complication in atopic dermatitis is a juvenile type of cataract. It involves the posterior portion of the lens and is slow growing.

Another complication in young children is changing sensitivities. A young individual sensitive to egg suddenly may become sensitive to milk, or there may develop a pollen or dust sensitivity. The allergic etiological factors in this disease are exactly those found in other allergic syndromes, e. g., asthma. In fact, the condition sometimes has been called asthma of the skin. It is not infrequent to find inhalants as etiological factors as well as seasonal elements of pollen and mold, and seasonal foods. Statistically, it probably can be said regarding foods that eggs are the most prominent offender followed closely by milk, oranges, wheat, chocolate, fish and nuts. In the individual case, however, there is no such thing as a statistical study.

All of the secondary factors that involve the other allergic diseases play an intense part. Sudden changes in temperature or in humidity as well as psychological elements can cause flare-ups.

Diagnosis

In atopic dermatitis, the diagnosis primarily is that of knowing the disease. The most important single factor is determining the diagnosis of allergy. Just as all that wheezes is not asthma, so all antecubital dermatitides are not allergic. Diagnosis is not easy because there are no pathognomonic signs, symptoms nor laboratory studies indicating allergenicity. It must be made by physical examination of the lesions, laboratory studies, differentiation from other types of skin disease and, above all, by eliciting an adequate history.

The etiological diagnosis is by history, skin tests, clinical trials, food diaries, elimination diets and, most important, the intelligent application of the mother's account of the child's reaction to help find the offending agent or agents. Nowhere in pediatrics or medicine is complete intelligent cooperation more vital with regard to diagnosis and treatment of a disease than here.

The differential diagnoses of infantile atopic dermatitis are seborrheic dermatitis, eczematoid bacterial infections, nummular eczema, contact dermatitis, eczematoid fungal reactions, Leiner's disease, Ritter's disease and atopic erythroderma. In the adult form the chief differential diagnoses are concerned with contact dermatitis, seborrhea, nummular eczema, neurodermatitis conseriptus and eczematoid fungal reactions.

Management

Management of this syndrome fits into the routine method of treatment in allergy. After the etiological agent is found, it should be eliminated or hyposensitization should be attempted. Nonspecific therapy with drugs and topical agents is necessary for interim use.

The elimination of foods is relatively easy and the results will be good provided that a certain food is the only etiological factor. Success in the elimination of the food requires the utmost cooperation on the part of the mother. Proper management of this disease practically depends on the mutual interest or doctor-mother standing since it is the mother, of course, who lives with the child and who is in position to uncover many of the hidden clues needed in determining the etiological factors involved. The mother also is the one to administer the diet, and the diet must be administered adequately or all is lost in dietary therapy.

Hyposensitization to Foods

Hyposensitization to foods is notoriously poor. Some allergists have been successful with the oral hyposensitization. In our experience, this has been a valuable adjunct in therapy in only a few cases.

Hyposensitization, however, deserves much consideration. It must be remembered that we are treating this disease in the acute phase. This would make our treatment that of a co-seasonal type. In this type of therapy dosage must be small, and the increasing dosage also must be small. Our dosage schedule for dust, for instance, begins with a very low concentration. Our own beginning dose is 1/10,000 concentration of dust, increasing the dose very slowly and preferably seeing the patient more frequently. This would correspond to the low dosage type of therapy.

The doses are built up slowly and this requires a good deal of reassurance to the mother that things are going well even though she doesn't note much change in the patient at first. To maintain the schedule, it must be advised that improvement will not be seen for many months from hyposensitization. Symptomatic therapy is used to control symptoms in the interim.

Repository Therapy

Since the introduction of repository therapy in the past few years, we have used it in about 75 cases. Our experience shows it to be a valuable adjunct to therapy in atopic dermatitis where hyposensitization is indicated. In young children we administer ½ cc. of the Drakeol Arlacel emulsion with small doses of the antigen, usually around 500 protein nitrogen units. This is repeated every 2 to 4 months. In older children and adults, we also administer small doses in a 1 cc. volume of emulsion. Results at present are being evaluated but it is our opinion that this method of hyposensitization is as good as, if not better than, routine aqueous therapy.

Symptomatic therapy, as the term indicates, means treatment of the symptoms. One must treat the itching. One must treat the dermatitis. The dermatitis is treated by conventional dermatological methods as described in many texts. The mild washes and lotions to the acute phases, the careful use of antibiotics where infection is noted, the sedation where the patient has a good deal of irritability, the definite anti-itch medication for itching, all are important in the well planned program of therapy.

The Steroids

The use of steroids in these cases is a moot question. In young children, we feel for the most part that their use is unnecessary. There comes a time in practice, however, when the use of steroids is of vast importance. This is especially so in the young female aged 11, 12 or 13 years who has had atopic dermatitis most of her life and is now beginning to feel the urge of fascinating the male. This patient has been under various types of treatment for long periods of time and is discouraged and resentful. She has become cynical and difficult to manage unless it can be proven to her that her skin can clear. She requires heroic measures to clear her skin quickly so that she can be kept as a cooperative patient to continue on her treatment.

It has been said that atopic dermatitis occurring in the individual past the age of 30 is incurable. This may or may not be so. In our experience we have seen cases that responded well although it must be admitted that we have also seen cases that responded poorly, even at earlier ages.

In summary, then, the treatment consists of adequate allergic management plus the logical use of symptomatic agents to give relief while the immunological processes are being attenuated.

The prognosis in atopic dermatitis must always be guarded. Although our statistics favor the control of this disease with good therapy, there is always the chance that the patient is not a statistical figure.

Atopic Dermatitis

A Semantic Ballad*

Prurigo's a term which seems to say
Somehow related to old Hebrae
While eczema's one of those mixed-up hashes
Composed of odds and ends of rashes.

And he who says neurodermite
Gives French psychiatrists a treat;
The use of neurodermatitis
Implies the patients have Saint Vitus!

Atopic derm, while not perfection
At least points in the right direction,
It says that here's a skin disease
More common in families that sneeze and wheeze,
That are stigmatized to varying degrees
By other abnormalities.

So for the present, at least for me
Atopic dermatitis it shall be —
And neurodermite will fade away
Like General MacArthur and prurigo Besnier.

And before I throw all my tars away
Put a couch in the place of my old grenz ray,
Before I discard Hydrocortisone creams,
And just quiz my patients about their dreams,
Before I accept that it's lack of embraces
Which makes the skin pop in the cubital spaces,
Before I grant that when wanting to cry,
The skin must weep if the eyes stay dry!
A lot more proof I shall have to see
And a lot more cures by psychiatree.

*Chicago, Ill. Dec. 8, 1954.

Psychiatric Factors

A special word should be said about the psychiatric (or psychosomatic, psychogenic or whatever the term) factor of this disease. Whether or not individuals acquire the disease as a result of psychiatric factors is not known. It would be hard to suppose that definite immunological processes occur as a psychosomatic response. Be that as it may, if this type of etiology does occur, the disease falls not in the realm of the allergist but in that of the psychiatrist.

There are, however, the secondary psychiatric factors resulting from a chronic disease that are very important to the allergist. They are insecurity and resentment built up by having this terrible disease. These patients require a lot of encouragement and understanding help. This is at the level of an environmental situation. These do not necessarily require psychiatric aid, but the tender loving comfort of a physician who is sure

of himself and who can gain the faith of his patient can be all important.

It has been our hope in this discourse to convince the allergists that atopic dermatitis is truly an allegric disease and that allergic management is a most important element in its control and in giving the most aid. Our results with allergic management have been good. It is true that we do not have better results with atopic dermatitis than we have with asthma but assuredly the results are not far worse, either. The disease need not be the bugaboo or the defeatist type of affair that has controlled medical thought. It is our feeling that if we discard the defeatist attitude toward the disease, our results will be much better.

In conclusion, a poem by Sulzberger[3] is quoted. (See page 139).

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Value of Seat Belts

It is seldom recognized that approximately 30 per cent of all vehicles manufactured are involved, at one time or another, in injury and fatality-producing accidents. A large number of these accidents occur at speeds of under 40 miles an hour. Physicians probably run more of a risk because of the substantial mileage they drive, often under hazardous conditions. The importance of using seat belts to minimize the effects of accidents on both short and long trips is well established. The automotive crash injury research at Cornell University and other highly-regarded studies show that many lives can be saved and countless disabling injuries avoided through the use of seat belts in automobiles. Yet many persons, including physicians, have not yet taken advantage of this important safety feature.

When an automobile crashes, the occupants continue to move forward until they hit either the street or some hard portion of the interior. The seat belt serves to "tie" the occupants in the vehicle so that when the vehicle crashes, their deceleration tends to be much less abrupt and consequently severe injury is sustained less often. Many injuries and deaths result from the driver or a passenger being ejected at the time of impact. Ejection occurs in about 14 per cent of injury-producing accidents. Researchers at Cornell found that ejection multiplies by five times the risk of dangerous or fatal injury. Seat belts keep people from being ejected. Other injuries and deaths result from striking the steering wheel assembly and other surfaces or objects in the car.

Some of the reasons people give for not using seat belts are that they tend to be uncomfortable, they take too long to put on and take off, and they get dirty if allowed to drag on the floor. How can these reasons be equated with the benefits? It is a proved fact that seat belt users have up to 35 per cent less risk of serious injury from these hazards than nonusers. Lap belts, the familiar types of seat belt used in this country, are inexpensive and simple to attach to cars, and if they are worn properly, they are comfortable. In fact, consistent users of seat belts say they are held more firmly in their seat, which adds to the comfort of riding. Passengers in the rear seat who are wearing seat belts also receive excellent protection.

Seat belts are not a panacea for all automobile injuries. But no one can dispute the fact that by using seat belts at all times, the chances of being injured or killed in an automobile accident are greatly diminished. The seat belt will keep the driver behind the wheel in any emergency maneuver, thereby giving him the opportunity he might need to get out of a serious situation. Seat belts also are designed to be opened easily with either hand so the passenger can free himself in seconds. Common sense dictates that seat belts should be a standard safety feature in all cars and that they should be used. You owe it to yourself, your family, and your patients to save yourself from injury by wearing seat belts. As a physician you have an excellent opportunity to set a good example for others to follow.—G. W. L., in New York State Journal of Medicine.

Primary Hodgkin's Disease of the Stomach*

(With Case Report)

William D. McClung, M. D.

Hodgkin's disease first was described in 1832. Even though the condition has been extensively investigated from both a clinical and pathological standpoint since that time, confusion and differences of opinion still prevail. Its etiology is unknown, treatment is empirical, its course is unpredictable and the pathology is subject to a variety of confusing classifications with resulting poor clinical correlation. For a comprehensive review of the entire subject, the reader is referred to that of Wallhauser,[1] the later work of Sternberg,[2] and the excellent monograph and reviews by Jackson and Parker.[3, 4, 5, 6]

This paper will not deal with the controversial aspects of Hodgkin's disease in general but will be limited to a brief discussion of that particular form in which the disease is confined to the stomach.

Although there still is some question of whether or not such an isolated variant of Hodgkin's disease really exists, a sufficient number of cases have been reported (even though rare) to indicate that a primary Hodgkin's granuloma arising in the stomach and remaining localized there for varying lengths of time can occur. Jackson and Parker are convinced that the generalized form of Hodgkin's disease may begin insidiously as an isolated and localized focus. They insist that it is no different from carcinoma in this respect and that early diagnosis and treatment are equally as important. Jackson,[16] in a review of the literature up to October, 1957, reported a total of 36 cases of isolated Hodgkin's disease of the stomach, including three of his own. Steenberg and Clough[12] in November, 1957, found 41 cases reported in the literature in which treatment consisted of subtotal gastric resection followed by radiation. Guest[18] published an eleven year summary (1948 through 1959) of cases of primary lymphosarcoma of the stomach encountered at Vanderbilt University Hospital and at Thayer Veterans Administration Hospital, Nashville, Tennessee. Of a total of 21 cases, two proved to be Hodgkin's disease. Jackson and Parker, in a series of 157 cases of Hodgkin's disease, reported definite clinical evidence of gastrointestinal lesions in 9, or 5 per cent. Six of these cases proved at autopsy to be primary in the gastrointestinal tract and confined almost entirely to the viscus concerned and the immediately adjacent lymph nodes. Three of these involved the stomach. Mead,[14] in a review of 16,254 autopsies, found only three cases of isolated gastrointestinal involvement. Goldman,[17] analyzing 212 cases of Hodgkin's disease, found only one in which there was stomach involvement.

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A review of approximately 5,000 consecutive autopsies performed in various hospitals in Charleston, West Virginia,[8, 9, 10] disclosed only seven cases of Hodgkin's disease and in none of these was there involvement of the gastrointestinal tract, either primary or secondary. From these figures it becomes apparent that the entity is uncommon.

Symptoms

There is nothing characteristic about the symptoms of Hodgkin's disease of the stomach. Anorexia is an early and prominent complaint and these patients lose weight because they don't eat although cachexia, as seen in carcinoma, is not prominent. Nausea and vomiting may occur, with occasional hematemesis (and melena) due to hemorrhage secondary to ulcer formation. As in carcinoma, pain is not an outstanding feature and, when present, usually is more severe and makes its appearance earlier in the course of the disease. A mass seldom is palpated. There may be varying degrees of anemia, usually hypochromic. The blood picture is variable and offers little help in diagnosis.

The x-ray findings are not specific and either resemble carcinoma, suggest a "lymphoma" or are misleading in underestimating the lesion. Peristaltic waves may continue even over a huge ulcer, due to the intact muscle fibers.[15, 18] Jackson,[16] in reviewing the 36 cases found in the

*Presented before the annual meeting of the West Virginia Chapter of the American College of Surgeons at The Greenbrier in White Sulphur Springs, April 14-15, 1961.

literature, stated that not one was diagnosed preoperatively.

Pathology

The Hodgkin's lesion usually begins with the development of a cellular infiltrate in the submucosa which gradually expands, displacing the surrounding tissue rather than destroying it.[18] The muscularis is preserved over the lesion even with extensive infiltration. Because of the infiltration and expanding tendency, the complications of perforation, massive hemorrhage and obstruction rarely are seen and then only late in the course of the disease. In this respect, the disease differs from carcinoma with its invasive and destructive characteristics and in which these complications are relatively common.

Grossly, the gastric lesion may appear as a polypoid, tumor-like mass projecting into the lumen, or as a broad based ulcer with firm, raised edges. It may lead to thickening of the entire wall, with marked accentuation of the normal rugae.

The microscopic picture is characterized by cellular infiltration consisting of more or less pleomorphous reticulum cells among which typical Reed-Sternberg cells can be identified; these elements are intermingled in varying proportion with eosinophils, plasma cells and occasional neutrophils. Necrosis and fibrosis often are seen.

Stout[11] insists that the diagnosis of Hodgkin's disease never should be made unless definite Reed-Sternberg multinucleated cells are present in a lesion. He states, "Only four such cases have been examined by the writer and in each one of them the tumor was a mass enlarging in the submucosa, projecting into the stomach with secondary ulceration and producing symptoms for which the stomach was resected. It was impossible to differentiate them grossly from lymphosarcoma."

Treatment

Although the surgical treatment of generalized Hodgkin's disease has been disappointing for the most part, subtotal gastrectomy followed by deep x-ray therapy appears to be the logical procedure in treating intrinsic gastric Hodgkin's disease. It is apparent that this form of therapy has evolved of usage since the surgeon cannot individualize the procedure preoperatively, being unaware of the true diagnosis until after the operation has been completed. Only then can the true pathology be determined by the pathologist, and x-ray therapy advised. Rapid frozen section is unreliable.[8] That the results of this method of treatment are proving relatively successful is indeed fortunate.

It is difficult to evaluate the results of x-ray therapy alone. Even though this is an accepted type of therapy in generalized Hodgkin's disease as well as in other lymphomas, an appraisal of its results in primary gastric involvement is difficult because of the inability to make a true diagnosis of a rare variant of an uncommon disease on the one hand and the meager autopsy data on the other.

Case Report

Mrs. J. O., a 49-year-old white female, was first seen in the office on February 7, 1959, complaining of mild but persistent pain in the epigastrium and right upper quadrant of six weeks' duration. The pain was unrelated to food intake. There was an associated nausea, with occasional vomiting. The pain did not radiate. There was no history of hematemesis nor of melena. The bowels moved regularly without laxatives. The past history revealed no serious illnesses, operations nor hospitalizations. The general physical examination was within normal limits except for mild hypertension. Weight 147 pounds.

Examination of the abdomen revealed moderate tenderness over the gallbladder region. No masses were palpated. There was no free fluid demonstrated in the abdomen. A large, irregular uterus was noted on pelvic examination.

An oral cholecystogram revealed no abnormalities.

The patient was placed on an antispasmodic type of therapy but returned to the office on March 14, 1959, complaining that her symptoms were getting worse. X-rays of the stomach at that time were reported as follows: "There is a slight deformity of the duodenal cap. There is a superficial ulcer crater with thickening of the mucosa of the duodenum consistent with an active, duodenal ulcer."

She was placed on routine anti-ulcer treatment consisting primarily of Probanthine, bland diet, mild sedation and antispasmodics. She improved somewhat on this regimen but on April 18, 1959, underwent emergency surgery for an acute, suppurative appendicitis. She recovered uneventfully from this illness but continued to complain of her original epigastric distress. X-rays of the stomach in August, 1959, and again in May, 1960, were reported as revealing no pathology.

She was not seen again until July 4, 1960, when the writer was called to her home. At this time she was complaining of severe colicky, epigastric pain associated with anorexia, of approximately three weeks' duration. She complained of constant nausea and had lost considerable weight.

She was admitted to the hospital for study. Physical examination was generally normal except for moderate epigastric tenderness, uterine fibroids and obvious weight loss. There were no masses palpable in the abdomen and the spleen could not be palpated. There was no demonstrable lymphadenopathy.

The hematocrit was 35 vol. per cent and the hemoglobin 11.5 Gm. WBC 9,150 with 35 per cent lymphocytes and 65 per cent segmented neutrophils. The urine was normal.

An x-ray of the chest was essentially normal with no evidence of hilar node enlargement. A barium enema was reported as normal. X-rays of the stomach were reported as follows: "Further studies of the esophagus, stomach and duodenum, after an interval of two months, now reveal a small defect on the greater curvature of the stomach having the appearance of an ulcer. A malignancy cannot be excluded particularly in view of the fact that it is on the greater curvature. The area was carefully reviewed on the studies made two months ago and this was not present at that time. Peristalsis appeared to pass through the area and it is possible that part of the defect may be due to extrinsic pressure."

A small bowel study revealed no abnormalities of the jejunum or ileum. The entire small bowel was empty in six hours.

In view of the questionable x-ray findings, the immediate symptoms, the history of operation for acute appendicitis and the presence of a pelvic mass, it was felt that a pelvic laparotomy with abdominal exploration was the procedure of choice.

At operation, July 8, 1960, a uterus with large fibroids was found. Both ovaries were normal. Palpation of the stomach revealed a flat, firm, rubbery mass approximately 10 cm. in diameter on its posterior wall in its distal third, encroaching on the greater curvature. The presence of so large a mass was entirely unsuspected and extremely surprising. Subtotal hysterectomy and bilateral salpingo-oophorectomy were carried out as rapidly as possible and the lower abdominal incision closed.

The abdomen was re-entered through an upper right paramedian incision and exploration of the stomach confirmed the existence of the mass as described above. There was no serosal involvement and the stomach was completely free of the surrounding structures except for its usual attachments. The liver was not remarkable on inspection and palpation. The spleen was not enlarged and showed no other unusual features. Several discrete lymph nodes were noted around the celiac axis as well as in the lesser omentum near the pyloric end of the stomach. Subtotal gastric resection with anterior gastrojejunostomy was accomplished without incident.

Microscopic examination revealed ". . . an infiltrating pleomorphic tumor consisting of numerous reticulum cells with sprinklings of eosinophils and some cells resembling the Reed-Sternberg. In some areas there are lymphocytes and polymorphonuclear leukocytes and focal areas of fibrosis. These cells are seen infiltrating into the submucosa and superficial muscularis. Sections of the lymph nodes show nonspecific reactive hyperplasia."

The final pathologic diagnosis was "Hodgkin's disease of the stomach with perigastric lymph nodes showing nonspecific reactive follicular hyperplasia."

The patient's postoperative course was uncomplicated and she was discharged on July 19, 1960, her eleventh postoperative day.

On August 8, 1960, a series of x-ray treatments consisting of a total of 800 r in air over the left upper quadrant was begun. She withstood this therapy nicely, complaining only of very mild nausea and slight malaise. Neither of these symptoms was incapacitating to any degree. At the completion of the x-ray therapy, her hemoglobin was 13.4 Gm., hematocrit 40 vol. per cent and WBC 6,100 with 27 per cent lymphocytes, 3 per cent monocytes, 61 per cent segmented neutrophils and 9 per cent eosinophils.

She remained symptom free and is returning periodically for follow-up examination.

Addendum

At examination on July 19, 1961, she presented no abnormal physical findings. X-ray of her chest revealed no hilar node involvement. A barium contrast study of the stomach showed a normally functioning anastomosis with no abnormalities noted in the remaining stomach, anastomosis or proximal jejunum. A flat film of the abdomen, taken for soft tissue study, revealed a spleen of usual size and no evidence of retroperitoneal masses. A complete blood count was normal in all respects.

She was last seen on January 25, 1962. She presented no complaints and general physical examination was normal. Repeat chest and gastrointestinal x-rays were reported as showing no change since the studies in July, 1961. The hematocrit was 44 vol. per cent, hemoglobin 15.4 Gm. and WBC 5,200, with 36 per cent lymphocytes, 63 per cent segmented neutrophils and 1 per cent eosinophils.

Comment

Evidence gradually is accumulating in the literature which lends considerable weight to the concept that Hodgkin's disease of the stomach can exist as a primary and localized lesion. The passing of time, with extended clinical follow-up, further operative findings and autopsy data will be necessary before this hypothesis can be accepted as factual. This is especially true when one considers the naturally bizarre and unpredictable course of this disease. In the light of recent literature, nevertheless, it is logical to assume that when confronted with such a problem, extirpation of the diseased tissue by subtotal gastric resection followed by postoperative radiation will result in prolonged relief of symptoms in a high per cent of cases. Time alone will decide a cure.

Summary

1. The occurrence of isolated Hodgkin's disease of the stomach as a specific entity is discussed. The existence of such a lesion has been gradually accepted chiefly as the result of accumulated case reports in the literature.

2. The nonspecific symptomatology, x-ray findings and gross pathological characteristics are emphasized. The importance of the microscopic pathology is stressed.

3. It appears that the treatment of choice is subtotal gastric resection followed by deep x-ray therapy.

4. The necessity of long-term follow-up after surgery before an absolute evaluation can be made is stressed.

5. A case of what appears to be primary Hodgkin's disease of the stomach is presented.

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Pressures of Great Events

If organized medicine is to win what seems to have become a political battle, it must redouble its efforts to persuade the public and the Congress of the inherent dangers to the American people that it is convinced are embodied in the new principle represented by H. R. 4222. This, too, is pressure, and unfortunately it must be exerted if the profession is to serve the public in what it sincerely believes is the most effective way, unhampered by accumulating political restrictions. As Hegel wrote, "Amid the pressure of great events, a general principle gives no help."—New England Journal of Medicine.

Special Article

The Sabbath of Life

Joseph Krimsky, M. D.

An ancient sage wrote these memorable words: *"Youth is not a time of life; it is a state of mind. People grow old by deserting their ideals. Years wrinkle the skin but giving up of enthusiasm wrinkles the soul. Worry, doubt, fear, self-distrust and despair—these are the long years that bow the head and turn the growing spirit back to dust—You are as old as your faith, as old as your doubt, as young as your self confidence, as old as your fear, as young as your hope, as old as your despair."—"He who is of a calm and serene nature will hardly feel the pressure of age."*

The pursuit of happiness is one of our inalienable rights. But the concept of happiness varies with different societies and in different individuals. Recreation, entertainment, art and craft workshops, all are essential and indispensable to retired and semi-retired elders but they may not add up to happiness if there is lacking that courtesy, that consideration, that affection which age requires and without which self-esteem and human dignity suffer, no matter how the economic needs are met.

The aged (in our youth-centered society) should not be made to feel useless and unwanted because they no longer tend the wheels of the industrial machine. Relaxation, contemplation, reflection, the wise and mature use of the blessed gift of leisure, the enjoyment and appreciation of cultural and religious values—these should be the uses of age in the hoped-for Sabbath of the years.

We can and do adjust to gradual changes which are normal in a growing and maturing society. When these changes are abrupt and drastic, as often is the case in compulsory retirement, trauma to mental and physical health frequently results. Sudden retirement from daily productive activity to idleness and inactivity leaves the door open to frustration, boredom and the nostalgic looking backward to "the good old days." Adjustment can be assisted and accelerated by pre-retirement planning and by the cooperation of family, community and medical counseling in averting the physical and mental deterioration which is preventable in normal senescence.

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Retardation of senility, with all of senility's unhappy accompaniments to the individual and his family, is a major task for the educational, social, economic, medical and ministerial resources of the community. The will to live and enjoy the remaining years must be sustained in the individual through his or her own efforts in coordination with the work of public and philanthropic agencies. While it is natural for the elderly to be more or less resistant to change, it nevertheless is true that the conservation and preservation of our treasured cultural and religious heritage must be credited largely to the wisdom, judgment and experience of our older men and women.

The chronic ailments of the aged not infrequently have their roots in bad nutritional and living habits in the earlier years, though it is inevitable that aging, even normal aging, is accompanied by involutional changes in heart, nerves, brain, blood vessels, kidneys and glands. The early recognition of these changes by regular and thorough medical checkups can bring about alleviation and amelioration that would spell ripeness, maturity, comfort and well being for the harvest years of the life cycle. The sad picture of deterioration in certain types of aging more usually is the consequence of unfavorable economic, social and other environmental conditions rather than of actual organic damage in the brain, heart and other organs.

Loneliness, idleness and the sense of being useless and finished bears much of the responsibility for the pathetic spectacle of premature senility. We are a young and vigorous nation worshipping the idol of mass material production and consumption. To be out of the running, to be retired in an active and dynamic community means to become, after a while, a forgotten man, unwanted and ignored. Before the aging individual is re-

tired from his gainful occupation, he should be given several years of preretirement training while still on the job. He should prepare himself through the cultivation of some fruitful hobby or avocation that would sustain his self-respect and independence during the latter years. To grow old enjoyably—to live longer and enjoy it more—demands an active participation by the aging in the civic, cultural and educational life of the community. And it is the task and duty of the community to encourage and facilitate such participation. Disengagement of millions of senior citizens from responsible sharing in the conduct of our national and communal affairs poses a grave threat to the future of our security, our stability and our progress.

Some of us are blessed with enthusiasm and the zest for life even after we have crossed the bar of three score years and ten which, in our scientific age, is no longer the accepted span of normal aging. What we term "genius" has a considerable admixture of enthusiasm. Think of the many poets, philosophers, painters, musicians, dramatists and other creative spirits who have enriched our history and our civilization with the work of their twilight years.

We are all aware that one of the most pitiful aspects of old age is the feeling of being alone—the sense of being left behind by the world of friends and fellow workers in which formerly we may have been "the life of the party." Man is a social animal. He needs company and companionship. But that does not imply that he must always run with the herd and graze with the flock. Solitude is not the same thing as loneliness. In a noisy crowd, whether in a resort hotel or at a cocktail party, one may feel utterly alone and forlorn. You may walk, strange and lonely, on a crowded city street. But you can revel in the most delightful company of the world's great spirits while reading in the quiet of the public library or in your own living room or while taking a walk in the park.

Hope, faith and love are our most loyal and devoted companions at any age, but especially in twilight years when we need them most. How we have lived our earlier years, how we have matured and adjusted will, to a large degree, determine our adjustment and integration in later life. Our attitude and relationship to our family, our neighbors, our community, our nation—these and our religious beliefs constitute the elements of our intellectual and emotional security and stability. And they will continue to do so, in modified form, as long as we live. Our physical and mental health and well-being have their foundations in the sound thinking and sound living during the years of our growth and our prime.

Service to others can bring joy and fullness to many hours that have been idled by retirement. The wisdom, experience and acquired skills of the aging should be a rich source of use and value in the many needs and welfare activities of the community. These services may be creative as well as recreative. Recreation is a prime necessity in young and old. In the aged it can be a means towards friendly and joyous diversions with each other and with the younger generations. Recreation can and should go hand in hand with adult education and with training in the arts and crafts. There are no more satisfying experiences in life, especially the life of leisure, than weaving a colorful scarf or fashioning a piece of pottery, or painting a landscape, no mater how crude and amateurish it may be. And it is the best medicine for good health.

It has been said that "*if an individual retires out of life, life retires out of him*"—"*If you left your dreams behind; if hope is cold; if you no longer look ahead; if your ambition's fires are dead, then you are old. But if from life you take the best; if in life you keep the zest; if love you hold, no matter how the years go by, no matter how the birthdays fly, you are not old.*"

To have and to hold a respected and responsible place in the community; to be esteemed, not alone for what one has, or has been, but for what one is and does in the community and in public service—that is the ideal way to grow old. Not just living longer but living more fully and with greater self-fulfillment. Don't waste the precious reserves in your life's bank account by giving way to resentment, to anger, to hate, to self-pity.

We can foresee the dawn of a new day when the Golden Years will be free of insecurity and the "canker of care"; when the pains and disabilities of senescence will be prevented or relieved by the best medical care that science can offer; and when the aged will be accorded the consideration, the courtesy and the affection they have earned from their children and from their fellow citizens.

Happiness dwells not alone with security and economic independence (essential as these are) but with the inner resources of faith, loving-kindness, patience, hope and, above all, equanimity. In the sabbath of life, it is a blessing to rest from our labors, to look back on the years of travail, the years of joys and sorrows, of accomplishments and failure, of triumph and defeat, of goodness and bitterness, and to give thanks in our hearts for the gift of the strength and the will to do our best.

95TH ANNUAL MEETING

of the

West Virginia State Medical Association

THE NEW WEST VIRGINIA WING

The Greenbrier

AUGUST 23-25, 1962

Plan to Attend — Make Your Reservation . . . Now !

The President's Page

Re: Our Population Explosion

A concern for the health of every individual is deeply rooted in the historic tradition of medicine. Furthermore, it is the desire of every physician that patients receive quality medical care unhampered by bureaucratic controls. The very fact that our society is rapidly changing economically, socially and geographically gives the social planners increased incentives to look for a remedy to every problem by governmental edict, rather than by the give and take of the market place. We realize our profession cannot remain static but as it becomes evident that change is necessary, we want to make our own decisions as to the solutions.

There has been an ever increasing demand for medical care in recent years. We have provided these services by increased efficiency in our practices, since the patient-physician ratio has remained rather constant for the past thirty years.

In the next few years it will be necessary to provide medical services for a greatly increased population. There also will be a disproportionate increase in the very young and the very old, with both groups requiring more than the average amount of care. There is rather general agreement that there will be a need for 4000 additional first-year medical students by 1970, so that by 1975 there will be 3500 more graduates annually.

A recent survey shows that by expansion of existing facilities in our present medical schools, places for 1700 additional freshman students could be provided. The remaining 2300 freshman seats would require 23 new medical schools by 1970. The cost of renovation of old schools and the building of 23 new schools of medicine is estimated at $1,208,000,000 over the next ten years.

The Health Profession's Educational Assistance Act of 1961 (H.R. 4999 and S. 1072) now before Congress would provide matching funds for medical school construction and renovation, as well as a loan fund for students. This legislation has received the support of the medical profession and it is anticipated that it may soon be passed and enacted into law. Announcements of plans for new medical schools have been delayed in many instances in anticipation of the passage of this grant-in-aid program.

Concern has been expressed in recent years because of the decreased number of qualified applicants to medical schools, and to the health professions generally. Competition from industry, the expense of the long years of study leading to a medical degree, earlier marriage and the possibility of governmental control have probably all contributed to this reduction. Certainly, we as physicians cannot assume a passive role but must lead in the recruitment of students. Many of our county societies and the auxiliary have been most active and successful in attracting students to careers in the health field. The first recipient of a four-year medical scholarship, awarded by the West Virginia State Medical Association, will receive his M. D. degree from the West Virginia University School of Medicine on June 4.

The new AMA-ERF Loan Fund should alleviate much of the financial worry of successful applicants to medical school, as well as those who would pursue additional graduate training. Five million dollars was available for loans as of March 1, 1962, and this fund is ever increasing.

A problem that may be even more difficult to resolve is that of procuring a sufficient number of qualified teachers for these new medical centers. It is from our current graduates that we will obtain our teachers of the future. During the year 1961 only four per cent of our graduates expressed a desire to go into teaching and research. Even today there are several hundred budgeted medical school positions unfilled. This situation will no doubt become worse in the future.

Although the present trend in medical education is toward full-time faculties, I am convinced more use can be made of the many competent physicians engaged in private practice. In addition, the facilities of many community hospitals with excellent approved intern and resident teaching programs are not being utilized to their fullest potential in providing educational experience to our students. These are questions that we must resolve in the near future. Whatever we may do in our efforts to increase the number of those engaged in health careers it is imperative that this not be at a sacrifice of quality.

D. E. Greeneltch

D. E. Greeneltch, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 343-4607.

EDITORIALS

NOW IS THE TIME TO REDOUBLE OUR EFFORTS

The Journal wishes to remind all members that time is running short and our efforts to defeat H.R. 4222 should be redoubled. In spite of governmental statement, this bill represents socialized medicine. It is compulsory medicine. It is medicine controlled and administered by the Federal Government through taxation. It is termed socialized medicine by the Socialist Party.

Physicians may sometimes feel that they are without friends in this endeavor to combat Federal encroachment. Indeed, we have been disappointed by the response from allied professions and ancillary groups. But in those counties in which a vigorous opposition has been staged, the response from all sectors of the population has been encouraging.

We believe our stand is right. It is surely an unselfish one. In spite of abuse heaped upon individuals and medical organizations by press and pressure groups, we shall continue to show the public the fallacies of this legislation and the advantage of opposing further development of the Welfare State.

The local societies and special committees have the materials and plans in hand to intensify our program of public education. The Chairman of the Committee on Medical Economics says, "the next month is vitally important."

"When a socializer tells you that the old people of this country are destitute, tell him that the 9 per cent of the population over 65 have 8 per cent of all personal income."

Without government meddling private industry will take care of more of our aged, and do it better if allowed the opportunity to continue our present hospital insurance program without interference.

MEDICAL COLLEGE ADMISSION TEST

Members of admissions committees of medical schools for a number of years have used the Medical College Admission Test (MCAT) as an aid in selecting students. The MCAT is designed to measure four factors: (1) knowledge of premedical sciences, (2) understanding of modern society, (3) verbal ability, and (4) quantitative ability.

Recently the Division of Basic Research of the Association of American Medical Colleges has released some data concerning the predictive value of the MCAT on the academic performance of high and low MCAT students.* A study was made of medical school accomplishment records of 100 first-year students entering in 1956 who had the highest score in verbal ability and in quantitative ability; another 100 students were selected who had the lowest score in these two areas.

It was found in the first-year class that 87 per cent of the students with the highest MCAT score made regular progress in medical school, namely they were promoted each year, and only about one in 20 failed their work. Of those in the lowest group, however, only about two-thirds made regular progress in medical school, and about one in six failed.

As far as grades were concerned, 52 per cent of the group with the highest MCAT score were in the upper third of the class, and only one out of ten in the lower third. Only 13 per cent of those in the low MCAT group were in the upper third of the class and four out of ten in the lower. In the third-year class approximately similar records were made.

It is apparent that the analyses show a positive relationship between MCAT level and student scholastic performance. It was pointed out, however, that the sampling was small, and that not many medical schools were represented. Furthermore, a number of students in the low MCAT group showed regular progress in their work and also made excellent grades.

It is obvious that other factors are concerned in scholastic performance. It was suggested that perhaps a combination of drive level plus certain patterns of personality characteristics played an important role. These factors may be of consequence in discriminating between students with a low MCAT score who do extremely well scholastically, and those, on the other hand, with a high MCAT score who do not do so well.

The entire matter obviously is complicated; for example, there is evidence that not all students strive to do their level best when taking the Medical College Admission Test. In some instances, the student may not have been feeling well physically the day he took the test, and, in still other instances, he may have been nervous and mentally upset during the test, and in either event he was unable to do his best. There are probably still more intangible factors operating which are difficult, if not impossible to evaluate.

In any event, it is too much to expect that any one test can predict with absolute accuracy the scholastic performance of all students in all medical schools. It does appear, however, that the MCAT score is of distinct value in many instances.

Be that as it may, practically every medical school in the United States requires the applicant to take the Medical College Admission Test and, furthermore, the score obtained is but one of several measures used in evaluating the fitness of a student to undertake the study of medicine.

*J. Med. Education 36:1733, 1961.

THE RIGHT WORD

Searching for the right word is generally a tedious pursuit. That it can become a pleasant pastime and one that pays off we have recently learned from one of our colleagues.

On April 22, 1962, *The Pittsburgh Press* announced that Dr. Doff D. Daniel of 200 Granville Avenue, Beckley, West Virginia, had won a $750.00 cash award for solving its Crossword Puzzle Contest. This is no ordinary crossword puzzle requiring simple understanding and dictionary definitions, but requires also a fine sense of proper connotation.

Nor is this the first time Doff Daniel has exercised his talent in this direction. He previously won $700.00 from a newspaper in Charleston for solving its crossword puzzle.

HIGHWAY FATALITIES

West Virginia Medicine through its President, Dr. D. E. Greenelteh, has given unqualified endorsement to the State Health Department's program to reduce highway fatalities. There is no field of public health or preventive medicine in which definite results may be secured in our mortality rates more readily than that area of accident prevention.

Through the development of driver instruction classes in our schools, motor vehicle operators get formal training and experience that definitely lowers our accident rate. At the other end of the age scale, physicians should urge elderly patients who have intervals of mental incapacity to refrain from driving cars. The matter of physical examination of the aged to determine driving responsibility is a field in medicine in which we should endeavor to establish some standards of capability. The increased longevity of our citizens does not necessarily indicate physical or mental competence in the operation of a dangerous vehicle. Physicians should also explore the legal right to recommend withdrawal of an operators license in the case of a recalcitrant patient.

Medical efforts to reduce built-in hazards of an automobile have heretofore been in vain and many dangerous features of construction and adornment continue to exist despite objections of qualified groups or committees of physicians.

It seems probable that restrictive legislation with regard to speed, caution, and rules of the road will have little effect. Medicine should continue to advocate those safety measures which have been shown to have even a modest effect on our accident rate.

Results can be obtained only by proper in-

doctrination of drivers in the development of responsibility toward their own vehicle and to the rights of others. All other considerations are secondary. What is the use of good roads and safety devices on good vehicles if the operator has a complete disregard for personal and public safety?

THE RIGHT TO DISAGREE

An interesting feature of medicine is the controversy and discussion that may develop over any medical problem. Such discussion extends into medical administration as well as the principles and practice of medicine. The physician is impressed with the medical subject or meeting that develops lively and heated conflict. It is not within the intellect of any one person or society to know just what is the best treatment or policy in a field of medical dissension.

This Association, its committees and its affiliates invites many authorities to our many meetings. Our Council and officers engage in discussion with medical and lay people in the effort to better the distribution of good medicine to all our people.

If disagreement develops as it inevitably must at times, let us try not to be disagreeable with our fellow discussant. An invited guest surely has the right to present his side of a problem without exposure to public recrimination from our members. *The Journal* upholds the right of a speaker at a medical session of our Association to "speak his piece" in the field of medicine or medical economics and will uphold his right to say, as he pleases, within the bounds of public propriety.

'Doctor Crisis' in Britain

Socialized medicine, medical care for the aged, etc., has intrigued a good many people of the United States, including President Kennedy. In the British Isles it has been in effect for a period of 14 years, and is about to collapse.

Doctors themselves have never liked it.

It is said that there are fewer medical students in Great Britain than there have been at any time during the past 100 years, and nearly one in every three who graduates is leaving the country for Australia, New Zealand, Canada, and the United States.

The British populace, putting up with tax-paid medical care, must depend on non-British doctors, mainly from India and Pakistan. Without them, it is conceded the health service would collapse.

All doctors in Britain are over-worked and underpaid. They sometimes must see 60 to 80 people a day, and the average income of a family doctor is about $6,700 a year. That's why young doctors by the hundreds have joined the exodus from Britain. They just don't like practicing medicine under bureaucratic control.

The talk in Britain is that the tax-paid system of treating the sick must either be violently over-hauled or abandoned altogether. The people themselves are disgusted with it. Though it is generally spoken of as socialized medical care, it has to be paid for. And since it doesn't give much satisfaction, it follows that it is not generally acceptable.

We people of the United States might well take a cue from Britain's experience, and not move into socialized medicine even with medicare for the aging element of our population. There may be occasional cases of inattention and neglect, as there always have been; but our free enterprise system of health care is still working pretty well.—*Charles Hodel, in the Beckley Post-Herald.*

'A Little Ol' Mailing Room'

The last time we looked the American Medical Association was under heavy fire because it maintains a lobby in Washington to fight the King-Anderson bill. It's all right for Jimmy Hoffa, say, to maintain a lobby, but when the AMA maintains one it's a social disease like phlebitis, maybe.

Well, as it turns out, the AMA isn't the only one lobbying on the King-Anderson bill. Over in a wing of the White House, says the *New York Herald-Tribune*, there is an office with six to 10 people in it, all of them busy as beavers preparing radio scripts, advertisements and publicity material for the King-Anderson bill and those who are seeking its passage.

Pierre Salinger says it isn't a lobby—nothing like that. The very idea! It's just a sort of little ol' mailing room where government workers "just sort of drop in" now and then to help out when they can.

This leaves unanswered the question as to who is paying for the paper, the postage, the time, the talent and the air conditioning, but we have Mr. Salinger's word that it's all on the up and up. Lobbying is what other people do. When the White House does it, it is educational.—*Charleston Daily Mail.*

The Headlong Rush Toward Disaster

If this country is to survive as anything resembling the democracy of stalwart individuals standing upon their feet through the free enterprise system that it was intended to be by the men who died at Lexington, Concord and Valley Forge almost two hundred years ago, the headlong rush toward the ultimate disaster of a welfare state must be discouraged.

Traditionally, the medical profession has always been in the forefront of this battle; even now we are under heavy fire to bring us, too, under the domination of the government. If we fail to stand firm, the cause is lost beyond redemption.—Frank G. Slaughter, M. D., in *Journal of Florida Medical Association.*

GENERAL NEWS

Surgeon General Heaton Honor Guest At Annual Meeting in August

Lieutenant General Leonard D. Heaton, Surgeon General of the United States Army, has accepted an invitation to appear as a guest speaker at the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier at White Sulphur Springs, August 23-25.

General Heaton, who is a native of Parkersburg, was appointed to his present position on June 1, 1959. He

Lt. Gen. Leonard D. Heaton

formerly served as Commanding General of Walter Reed Army Medical Center in Washington, D. C.

First Speaker on Program

Dr. Halvard Wanger of Shepherdstown, Chairman of the Program Committee, announced that General Heaton will be the first speaker on the program arranged for Thursday morning, August 23. His address will follow opening remarks by Doctor Wanger and Dr. D. E. Greeneltch of Wheeling, President of the West Virginia State Medical Association. His subject will be announced at a later date.

General Heaton attended Denison University in Granville, Ohio, and he received his M. D. degree from the University of Louisville School of Medicine in 1926.

After entering the military service in 1926 as a First Lieutenant, Medical Corps Reserve, he interned at Letterman General Hospital in San Francisco, California, 1926-27, and was commissioned as a First Lieutenant, MC, Regular Army, on August 3, 1927.

General Heaton graduated from the Army Medical School and the Medical Field Service School in 1929. Following his internship he was assigned to surgery at Letterman General Hospital in San Francisco. He later served on the Surgical Service at Walter Reed General Hospital in Washington, D. C.; Beaumont General Hospital at El Paso, Texas; Tripler General Hospital, Hawaii; and the Station Hospital at Fort Sam Houston in Texas.

Served at Schofield Barracks

At the time of the Japanese attack on Pearl Harbor, he was serving as Chief of Surgery at the North Sector General Hospital, Schofield Barracks.

He also has served as Executive Officer of Woodrow Wilson General Hospital in Staunton, Virginia; and Commanding Officer of the 160th General Hospital and Commanding Officer of the 802nd Hospital Center, Blanford, England.

He was Chief of the Surgical Service and Commanding General at Letterman General Hospital in San Francisco; and Commanding General, Walter Reed Army Medical Center in Washington.

He was promoted to Brigadier General in 1948 and Major General in 1950. After taking the oath of office as Surgeon General of the Army in 1959, he was appointed to the rank of Lieutenant General.

General Heaton is a diplomate of the American Board of Surgery and is a member of the American Medical Association, American College of Surgeons, American College of Physicians, American Surgical Association, International Society of Surgery, Pacific Coast Surgical Association, and the Association of Military Surgeons.

General Heaton was awarded an honorary Doctor of Science degree in 1958 by Denison University and, in 1959, he received an honorary Doctor of Science degree from the University of Louisville School of Medicine.

Scientific Program

Plans for the three general scientific sessions are nearing completion. The Program Committee announced previously the names of the following physicians and surgeons who have accepted invitations to present papers:

Dr. William S. Middleton, Chief Medical Director of the Veterans Administration; Dr. Alfred E. Maumenee, Professor of Ophthalmology at Johns Hopkins University School of Medicine; Dr. I. S. Ravdin, Professor of Surgery and Vice President of Medical Affairs at the University of Pennsylvania; Dr. Irving S. Wright, Professor of Clinical Medicine at Cornell University Medical College; Dr. Stewart G. Wolf, Professor and Head of the Department of Medicine at the University of Oklahoma School of Medicine, and Dr. H. L. Riva, Professor and Chairman of the Department of Obstetrics and Gynecology at Seton Hall College of Medicine.

Section Meetings

Several of the guest speakers have also accepted invitations to appear on programs being arranged by the Association's sections and affiliated societies which will be held afternoons during the three-day meeting.

Dr. George M. Fister of Ogden, Utah, who will be installed as President of the AMA later this month, will be among the honor guests at The Greenbrier. He will speak before the final session of the House of Delegates on Saturday afternoon, August 25.

The first session of the House of Delegates will be held on Wednesday evening, August 22, at which time Dr. D. E. Greeneltch of Wheeling, President of the State Medical Association, will deliver his Presidential Address.

Additional information concerning the program will appear in the July issue of *The Journal.* The complete program will be published in the Convention Number in August.

Tape Recordings on Everyday Office Problems Available

More than 250 one-hour tape recordings devoted to comprehensive and penetrating discussions of everyday office problems have been made available by the Audio-Digest Foundation, a non-profit subsidiary of the California Medical Association.

According to the Foundation's Medical Board, the 1962 "Catalog of Classics" makes available to individual physicians, hospitals and clinics, ideal program and teaching material in six specialty areas: anesthesiology, obstetrics-gynecology, surgery, internal medicine, pediatrics and general practice.

Copies of the new catalog may be obtained by writing the Foundation at 619 South Westlake Avenue, Los Angeles 57, California.

ACP Regional Meeting, Nov. 2-3

A regional meeting of the American College of Physicians will be held at The Greenbrier in White Sulphur Springs, November 2-3.

Dr. R. U. Drinkard of Wheeling, Governor of the West Virginia Chapter, ACP, announced that physicians from Western Pennsylvania, Ohio and West Virginia will attend the two-day meeting. The annual meeting of the West Virginia Society of Internal Medicine will be held in conjunction with the regional meeting.

Huntington VA Hospital Preparing For Possible Nuclear Attack

Dr. George M. Lyon, Director of the Huntington VA Hospital, announced recently that the Veterans Administration, in cooperation with the Office of Civil Defense, is preparing its medical system to be able to care for mass casualties should a nuclear attack ever occur.

Doctor Lyon said that in such an emergency, VA personnel would operate not only their own hospital and clinic system, but also Civil Defense Emergency hospitals.

These "packaged" hospitals are now being stored at VA installations. VA and community personnel are being taught how to set up and operate them.

Doctor Lyon said the VA's 170 hospitals and 91 outpatient clinics could provide the basic necessities of medical care for 350,000 patients in a national emergency. In addition, VA personnel could care for additional numbers when the "packaged" hospitals augmented bed space.

The VA's system of radioisotope laboratories provides an important resource of equipment and trained personnel for detection of radiation and care of persons exposed.

Doctor Lyon said that in accordance with Civil Defense guidelines, each VA medical installation has developed and practiced a plan for action in national emergency. If necessary, each hospital and clinic would operate on a completely local or independent basis during the first few days or weeks of a disaster period.

Patterned after the mobile U.S. Army surgical hospital used in Korea, the Civil Defense hospital is a packaged unit designed to meet disaster needs. It provides for care of 200 patients for 36 to 48 hours.

Doctor Lyon said the entire assembly of 350 crates contains 200 cots and basic necessities for an emergency operating room, a central supply unit, a portable x-ray unit of the polaroid type, equipment for a pharmacy and a clinical laboratory, a generator for electricity, and a collapsible 1,500-gallon water treatment tank.

More than 1,900 of these hospitals have been stored at sites throughout the nation. Others are being assembled and positioned by Civil Defense authorities.

Tents are not included, but the hospitals can operate in almost any building that provides enough floor space. Hospitals, schools or churches could be utilized. About 70 employees, including five physicians and 15 nurses, can set up and operate one of the hospitals in two hours.

The VA-sponsored demonstrations of the hospitals include unpacking and setting up the facility, admission, sorting and treatment of simulated casualties, and a critical evaluation of the entire exercise.

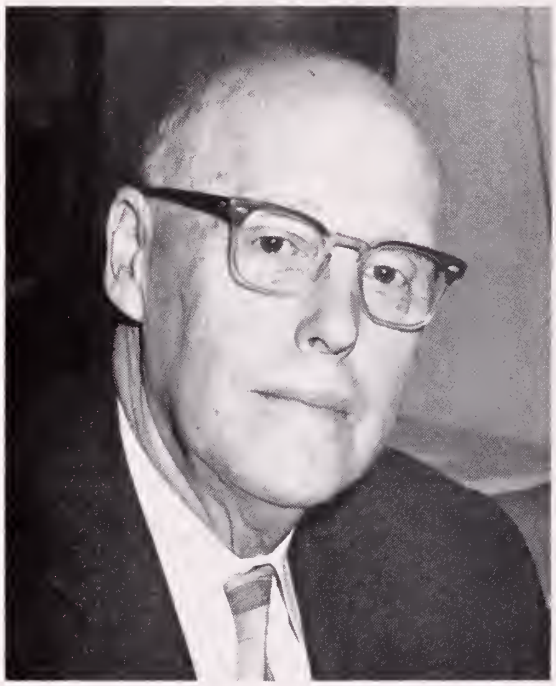
Doctor Lyon said the Huntington VA hospital regularly conducts exercises in the reception of mass casualties where it is assumed the hospital is intact. It also conducts exercises in situations assumed to be those associated with radioactive fallout subsequent to an atomic attack.

Dr. Dyer Awarded Honorary Degree By Marshall University

Dr. N. H. Dyer of Charleston, State Director of Health, was awarded an honorary Doctor of Public Administration degree by Marshall University, during commencement exercises held in Huntington on May 27.

"He has been aggressive, courageous and far-sighted in his professional leadership," University President Stewart H. Smith said of Doctor Dyer. "We regard him as an outstanding public servant in West Virginia."

Doctor Dyer attended West Virginia Wesleyan College and received a B. S. degree from West Virginia



N. H. Dyer, M. D.

University. He received his M. D. degree in 1926 from the University of Maryland School of Medicine and an M. P. H. degree from the University of Michigan in 1951.

He served as medical director of the Pond Creek Pocahontas Company at Bartley, McDowell County, for 20 years before his appointment as State Health Commissioner in 1946. In 1949, he was named State Director of Health.

A former president of the McDowell County Medical Society, Doctor Dyer also served on the McDowell County Board of Education for 16 years and at one time was president of that body.

In the Marshall University announcement, Doctor Dyer was cited as the "motivating person behind establishment of the State Board of Health," and as being in the "forefront as an advocate of cleaning up waste and filth from our streams and communities."

Doctor Dyer is the administrator of the Hill-Burton Authority in West Virginia. It has provided $31.5 million in federal funds toward $81.3 million in new hospital construction within the state since 1947.

He has served as consultant to the Surgeon General of the United States, as an original signer of the compact for West Virginia in the Ohio River Sanitation Commission, and as a member of the visiting committee of the West Virginia University School of Medicine.

Doctor Dyer is chief of the Medical and Health Services Division of the West Virginia Office of Civil and Defense Mobilization and medical director of the Reserve Corps of the U.S. Public Health Service.

He is a fellow of the American Public Health Association and a member of the Royal Society of Health of London, England, and a member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Doctor Dyer also is chairman of the Committee for Health, Education and Welfare for the West Virginia Centennial in 1963, and is a member of the Governor's Commission on Aging, State Rehabilitation Advisory Council, Governor's Commission on the Handicapped and Advisory Council to the State Board of Examiners for Registered Nurses.

Nine Points Check List Prepared For Treatment of Diabetes

Dr. Richard N. O'Dell of Charleston, Governor for the State of West Virginia, American Diabetes Association, announced that the following statement on the treatment of diabetes has been approved by the Association's Sub-Committee on Teaching of Diabetes in Hospitals of the Committee on Professional Education:

"Because of its prevalence and chronicity, diabetes mellitus should be the continuing concern of all physicians, regardless of their type of practice. An essential part of treating the condition is teaching the patient how to live with it.

"As in any educational program, a systematic approach should be used. Each physician should have certain specific objectives clearly in mind as he teaches his diabetic patients.

"To aid him, the American Diabetes Association has prepared the following check list of nine basic elements of treatment, which constitutes a minimum program for diabetes management:

"(1) Diet, (2) Urine testing, (3) Action of insulin and other hypoglycemic agents, (4) Technique of insulin injection and sites for it, (5) Care of syringe and of insulin, (6) Symptoms of hypoglycemia, (7) Symptoms of uncontrolled diabetes, (8) Care of the feet, and (9) What to do in case of acute complications.

"This guide is not only of value in the initial education of a new diabetic, but can also be most helpful to both patient and physician in the subsequent years of management."

Dr. George J. Hamwi of Columbus, Ohio, is chairman of the sub-committee, and Dr. Thomas H. McGavack of Martinsburg is the vice chairman.

An archaeologist is the best husband any woman can have: the older she gets, the more interested he is in her.—Agatha Christie.

ACCP To Hold Annual Meeting In Chicago, June 21-25

The American College of Chest Physicians will hold its five-day annual meeting at the Morrison Hotel in Chicago, June 21-25.

Postgraduate seminars, open forums, a cine symposium, round table luncheon sessions, and motion pictures will be included in the scientific program. Also covered will be such topics as tuberculosis, underwater physiology, chest roentgenology, cardiopulmonary, trauma, histoplasmosis, congenital heart disease and cardiac surgery.

The annual Presidents' Banquet, at which the College Gold Medal will be awarded to a physician for meritorious achievement in chest diseases, will be held on Sunday, June 24.

There will be a joint meeting on June 25 between the ACCP and the AMA at McCormick Place, Chicago's new convention center. This program will include, in addition to the regular scientific sessions, six round table luncheon sessions and will deal with such topics as surgical treatment of acquired cardiovascular diseases, special problems in diseases of the chest, and inhalation therapy.

Two AAGP Staff Changes

Dr. Thomas H. Bate has been named director of the division of medical education of the American Academy of General Practice.

Doctor Bate also will serve as secretary of the AAGP Commission on Education. Charles E. Nyberg, who held that post for 12 years, has been named assistant executive director.

$300 Million on Headaches

An estimated $300 million is spent each year in the United States by headache victims on popular "remedies," according to a brochure prepared by the U. S. Public Health Service.

"Headache—Hope Through Research" explains some of the causes and types of headache and reviews the latest treatments known to medical science. The publication also tells of the efforts of medical research to learn the secrets behind this condition.

Physicians may obtain single free copies from the Public Health Service. Orders under 100 are ten cents a copy from the Superintendent of Documents, Government Printing Office, Washington, 25, D. C. There is a 25 per cent discount on orders of 100 or more going to one address.

Rocky Mountain Cancer Conference In Denver, July 13-14

The 16th annual Rocky Mountain Cancer Conference will be held at the Brown Palace West Hotel in Denver, Colorado, July 13-14. The Conference will be co-sponsored by the Colorado Division of the American Cancer Society and the Colorado Medical Society.

Morning sessions during the two-day meeting will feature panel discussions on "Neoplasms Complicating Pregnancies" and "Carcinoma of the Colon." There will be roundtable discussions during the luncheon periods and individual papers will be presented during the afternoon sessions.

Further information may be obtained by writing Rocky Mountain Cancer Conference, 1809 East 18th Avenue, Denver 18, Colorado.

Dr. Edward R. Annis of Miami, Florida (right), chairman of the AMA Speakers Bureau, made three appearances in Charleston on April 17. Shown with Doctor Annis are, left to right, Dr. D. E. Greenleich of Wheeling, President of the State Medical Association; Dr. James S. Klumpp of Huntington, Chairman of the Medical Economics Committee; and Dr. Robert C. Bock of Charleston, President of the Kanawha Medical Society. (Photo courtesy of the Charleston Daily Mail).

Dr. Francis L. Coffey New President Of W. Va. Chapter, ACS

Dr. Francis L. Coffey of Huntington was installed as president of the West Virginia Chapter of the American College of Surgeons during the annual meeting of that organization which was held at The Greenbrier in White Sulphur Springs, April 12-14. He succeeds Dr. Victor S. Skaff of Charleston.

Dr. Jack C. Morgan of Fairmont was elected vice president, and Dr. E. F. Heiskell, Jr. of Morgantown, was named secretary-treasurer. Elected as councillors

New officers of the West Virginia Chapter, American College of Surgeons, are shown following their election at the annual meeting of the Chapter at The Greenbrier, April 12-14. Left to right (seated), Dr. Jack C. Morgan of Fairmont, vice president; Dr. Francis L. Coffey of Huntington, president; and Dr. E. F. Heiskell, Jr., of Morgantown, secretary-treasurer. Standing, Dr. Ray E. Burger of Welch, councillor; Dr. Victor S. Skaff of Charleston, retiring president; and Dr. Kenneth G. MacDonald of Charleston, councillor.

were Drs. Ray E. Berger of Welch, and Kenneth G. MacDonald and Victor S. Skaff of Charleston.

Dr. Charles M. Scott of Bluefield, a past president of the organization, was named Governor of the West Virginia Chapter, ACS, succeeding Dr. John O. Rankin of Wheeling.

The out-of-state speaker on the scientific program was Dr. Robert J. Coffey, Professor of Surgery at Georgetown University School of Medicine in Washington, D. C. He presented papers on "Experiences in the Diagnosis and Treatment of Hyperparathyroidism," and "A Reevaluation of Treatment of Pancreatic and Periampullary Tumors."

Cash prizes were awarded for the two best papers presented by residents. First prize of $100 was won by Dr. Gordon P. Holt of the West Virginia University Medical Center, whose subject was "Non-Suture Technique for Small Artery Anastamosis."

Dr. Marsh Holt, also of the University Medical Center, was awarded second prize of $50 for a paper on "Gastric Cooling for Upper Gastrointestinal Bleeding."

38th Public Health Conference In Huntington, June 7-8

"Reexamining our Responsibilities in Today's World" will be the theme for the 38th Annual Conference of the West Virginia Public Health Association which will be held at the Hotel Frederick in Huntington, June 7-8.

The first general session will be held on Thursday morning, June 7, and will be devoted to a seminar on "Viral Hepatitis."

Speakers will include Dr. Emil E. Palmquist, Regional Health Director, USPHS, who will present a summary report on "Viral Hepatitis;" and Dr. Heinz F. Eichenwald, Professor of Pediatrics at Cornell University Medical College, whose subject will be "Viral Hepatitis—An Elaboration of Principles and Facts."

Dr. L A. Dickerson, Director of the Division of Disease Control, State Department of Health, will serve as moderator of a panel discussion which will consider "Viral Hepatitis—West Virginia Policies and Programs." Dr. N. H. Dyer, State Director of Health, will present a summary of the situation on hepatitis in the State.

The second general session will be held on Friday morning, June 8. Speakers will include:

Ray George, Director of the West Virginia Community Clean-Up Program, who will discuss "Clean-Up Campaign as it Relates to Public Health;" Dr. A. L. Chapman, Assistant Surgeon General and Chief of the Division of Accident Prevention, USPHS, who will speak on "The Role of Public Health and Accident Prevention;" William V. White, Chief, Family Safety Branch, Division of Accident Prevention, USPHS, whose subject will be "Home and Farm Accidents;" and Dr. Ronald E. Crissey of Huntington, who will discuss "Power Mower Injuries."

Meetings of the various sections of the Association will be held on Thursday and Friday afternoons.

A reception honoring the president of the Association will be held on Friday evening and will be followed by a banquet in the Georgian Terrace Room of the Hotel Frederick.

Medical Meetings, 1962

The following is a partial list of national, state and district medical meetings scheduled for 1962:

June 6-8—W. Va. PH Association, Huntington.
June 21-25—ACCP, Morrison Hotel, Chicago.
June 24-28—AMA Annual Meeting, Chicago.
June 28-29—Seminar on "The Adolescent," WVU Medical Center, Morgantown.
Aug. 16-18—W. Va. Hospital Assn., White Sul. Springs.
Aug. 23-25—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 13-16—PG Institute, Martinsburg.
Sept. 17-20—American Hospital Assn., Chicago.
Sept. 20-21—W. Va. Heart Assn., Morgantown.
Oct. 9-11—W. Va. TB and Health Assn., Beckley.
Oct. 22-23—American Cancer Soc., New York.
Nov. 2-4—ACP Regional Meeting, White Sul. Springs.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 24-25—ACCP, Ambassador Hotel, Los Angeles.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.

New Association Members

Dr. Leopoldo Hernandez, 208 Virginia Street, West Hamlin (Cabell). Doctor Hernandez, a native of Mexico, was graduated from La Sierra-Arlington College in California, and received his M. D. degree from the University of Nuevd Leon in Mexico in 1954. He served an internship at Allegheny General Hospital in Pittsburgh, 1958-59, and had postgraduate training at the University of Cincinnati College of Industrial Medicine. He is engaged in general practice.

* * * *

Dr. Donald H. Hofreuter, 2270 National Road, Wheeling (Ohio). Doctor Hofreuter was born in Wheeling and was graduated from Princeton University. He received his M. D. degree from Columbia University College of Physicians and Surgeons, New York, in 1958. He served an internship at Allegheny General Hospital in Pittsburgh, 1958-59, and had postgraduate work at the University of Cincinnati College of Industrial Medicine. He is engaged in general practice.

* * * *

Dr. Francis H. Hughes, Jr., 215 11th Street, Parkersburg (Parkersburg Academy). Doctor Hughes, a native of Spencer, was graduated from Salem College and received his M. D. degree from the George Washington University School of Medicine in 1950. He served an internship and had residency training at Walter Reed Army Hospital. He served with the Medical Corps of the United States Marines for three years, and for nine years with the Medical Corps of the United States Army. His specialty is orthopedic surgery.

* * * *

Dr. Leo S. Konieczny, 526 7th Street, Huntington (Cabell). Doctor Konieczny was born in Bayonne, New Jersey, and he received his M. D. degree from the Loyola University School of Medicine in Chicago in 1946. He interned at the United States Naval Hospital in Oakland, Maryland, 1946-47, and served a residency at St. Michael's Hospital in Newark, New Jersey, 1950-52. He also took postgraduate work at the University of Pennsylvania Graduate School of Medicine, and was previously located in Ironton, Ohio. His specialty is pediatrics.

* * * *

Dr. Thomas C. McKee, Marshall University Student Health Service, Huntington (Cabell). Doctor McKee, a native of Kittanning, Pennsylvania, was graduated from the University of Pittsburgh and attended the two-year School of Medicine at West Virginia University. He received his M. D. degree in 1929 from the University of Pennsylvania School of Medicine and interned at West Pennsylvania Hospital in Pittsburgh, 1929-30. He served with the Medical Corps of the United States Army and retired with the rank of Colonel.

* * * *

Dr. David H. Smith, the Wheeling Clinic, Wheeling (Ohio). Doctor Smith, a native of Frank, Alberta, Canada, was graduated from the University of Alberta and received his M. D. degree from the Medical School of that institution in 1953. He served his internship at Edmonton General Hospital, 1953-54, and served residencies at Warren State Hospital, Norristown State Hospital and Utica State Hospital, 1954-58. He served with the Canadian Navy, 1940-45. His specialty is psychiatry.

New Telephone Number

The telephone number has been changed in the headquarters offices of the West Virginia State Medical Association in Charleston. The new number is 343-4607.

Institutional Man

There is more religion outside church than in, more love outside marriage than in, more poetry outside verse than in. Everyone knows there is more love outside the institutions than in, and yet I'm kind of an institutional man.—Robert Frost.

Speakers at the annual meeting of the West Virginia Chapter, ACS, at The Greenbrier included (left to right), Dr. Marsh Holt of Morgantown; Dr. Robert J. Coffey of Washington, D. C.; Dr. Francis L. Coffey of Huntington, president; and Dr. Gordon P. Holt of Morgantown.

Large Attendance Expected at Annual AMA Meeting in Chicago

More than 15,000 physicians are expected to attend the 111th annual meeting of the American Medical Association which will be held at Chicago's McCormick Place, June 24-28. Several thousand members of the Woman's Auxiliary are also expected to be in attendance for that organization's annual meeting which will be held during the same week.

General headquarters for the meeting will be the Palmer House, where the AMA House of Delegates will meet throughout the week.

All of the scientific and industrial exhibits and all of the general scientific sessions and meetings of the 21

Leonard W. Larson, M. D.

George M. Fister, M. D.

sections will be held under the same roof for the first time. Site of the meeting will be Chicago's giant new auditorium and convention hall, McCormick Place, newly opened on the shore of Lake Michigan, a short distance south of the Loop.

McCormick Place is completely air-conditioned and is well supplied with restaurants and other facilities to serve the large number of physicians expected to register for the meeting.

Presiding at the meeting will be Dr. Leonard W. Larson of Bismarck, North Dakota, AMA President. He will deliver addresses before the House of Delegates and Auxiliary, and will participate in inaugural ceremonies for Dr. George M. Fister of Ogden, Utah, who will succeed him as President.

State Delegates to Attend Meeting

The West Virginia State Medical Association will be represented at meetings of the House of Delegates by Drs. Charles A. Hoffman of Huntington and Frank J. Holroyd of Princeton. The alternate delegates are Drs. J. C. Huffman of Buckhannon and Thomas G. Reed of Charleston.

In addition to his duties as a delegate, Doctor Hoffman will participate in the scientific program which will be presented by the AMA Section on Urology.

Doctor Hoffman has accepted an invitation to serve as the discussant of a paper on "Traumatic Injuries of the Bladder and Urethra," which will be presented by Dr. Edgar Burns of New Orleans.

'Medicine in the Atomic Age'

The theme of the scientific program for the annual meeting will be "Medicine in the Atomic Age."

Eminent physicians and research scientists from throughout the nation will bring to physicians in attendance the latest word on developments and findings in research and in therapy in many of the major disease areas confronting the physician in practice.

Eight Half-Day Sessions

The eight half-day general scientific meetings are indicative of the broad scope of the scientific program of the annual meeting. General scientific meetings will be presented on Inhalation Therapy; Clinical Cardiology and Anticoagulant Therapy; Diagnostic Problems and Exfoliative Cytologic Methods; Tissue Transplantation; Inflammatory and Ulcerative Diseases of the Small Intestine; Teenagers' Problems; Mental Health, and Nuclear Medicine.

In addition, the Multiple Disciplinary Research Forum, which proved so successful at the New York meeting for the first time last June, will be repeated at the Chicago meeting.

The complete program for the AMA meeting may be found in the May 19 issue of the *JAMA*.

Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

Community Preparedness Theme For Disaster Meeting

"Community Preparedness for Emergencies" will be the theme of the 10th annual National Conference on Disaster Medical Care at the Palmer House in Chicago, June 23.

The one-day meeting immediately precedes the opening of the American Medical Association's 111th annual meeting and is sponsored by the AMA's Council on National Security.

The three-section program was developed and will be presented by the Division of Health Mobilization of the United States Public Health Service. The sections are: means of achieving community preparedness; meeting the needs of the public; and newer techniques designed to help meet professional needs.

Surgeon General Luther L. Terry will deliver the keynote address on "Preparedness at the Community Level—an Urgent Goal." More than 500 physicians, public health officers and civil defense personnel will attend the conference.

Additional information may be obtained by writing to the Department of National Security, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

AMA Woman's Auxiliary To Meet In Chicago, June 24-28

The 39th annual convention of the Woman's Auxiliary to the American Medical Association will be held at the Pick-Congress Hotel in Chicago, June 24-28.

Mrs. Vernon L. Dyer

More than 3,000 wives of physicians are expected to attend the meeting which is being held in conjunction with the annual meeting of the AMA. Tips on keeping husbands healthy and "Washington Legislation and American Medicine" are two of the topics which will be discussed during the meeting.

Mrs. Vernon L. Dyer of Petersburg, president of the Woman's Auxiliary to the West Virginia State Medical Association, will head the West Virginia delegation. She also was named to serve as a member of the Resolutions Committee.

Other delegates and alternates who have indicated they plan to attend are: Mrs. Howard G. Weiler and Mrs. D. E. Greeneltch, both of Wheeling; Mrs. C. L. Goodhand of Parkersburg; Mrs. P. A. Tuckwiller of Charleston; Mrs. Charles J. Sites of Franklin; Mrs. Lysle T. Veach of Petersburg, and Mrs. Buford W. McNeer of Hinton.

The convention will be convened formally on Monday morning, June 25, with reports of officers and chairmen and election of the 1963 nominating committee. A preliminary session will be held on Sunday, June 24.

The annual tea and choral program honoring the president, Mrs. Harlan English of Danville, Illinois, and the president elect, Mrs. William G. Thuss of Birmingham, Alabama, will be held Monday afternoon.

National past presidents of the Auxiliary will be honored at Tuesday's luncheon. The guest speaker will be Dr. Leonard W. Larson, AMA president. The Auxiliary at this time will announce its contribution to the nation's medical schools through AMA-ERF. Awards of merit also will be presented to the state and county auxiliaries contributing the most to this project.

New national officers and committee chairmen will be introduced at Thursday's workshop. A special invitation is extended to all members of medical society advisory committees to state and county auxiliaries and state and county executive secretaries to attend the Thursday morning session.

Throughout the week a full schedule of activities has been planned for teen-agers accompanying their parents to the meeting.

Auxiliary members and their guests may register at the Pick-Congress Hotel on Sunday afternoon, all day Monday and Tuesday and until noon on Wednesday and Thursday.

Doctor Scherr Presents Paper At Conference in Mexico

Dr. Merle S. Scherr of Charleston was among the speakers at the National Medical Congress of Pediatric Emergencies, Traumatology and Legal Medicine, which was held in Mexico City, April 22-26. The five-day meeting was held under the auspices of the Mayor of Mexico City.

Dr. Merle S. Scherr of Charleston, right, presents flag of the State of West Virginia to Mexican President A. Lopez Mateos, center, and Mayor E. P. Uruchurtu, left, of Mexico City.

He also presented lectures on allergy at the Medical School of the National University of Mexico and the Medical School of the Instituto Politecnico Nacional.

Subjects discussed by Doctor Scherr included Allergic Dermatoses and Their Management; Management and Rehabilitation of the Asthmatic Child; Repository Emulsion Therapy of Immunological and Allergic Diseases, and Management of Allergic Emergencies.

Doctor Scherr also presented greetings and gifts from Gov. W. W. Barron and the State of West Virginia to Mexican President A. Lopez Mateos and E. P. Uruchurtu, Mayor of Mexico City. The gifts included a West Virginia flag and a set of crystal manufactured in Morgantown.

He discussed with Mexican officials the utilization of that nation's medical school graduates as interns and residents in American hospitals.

Cancer Society Meeting in New York

The annual scientific session of the American Cancer Society will be held at the Biltmore Hotel in New York City, October 22-23. The theme of the two-day meeting will be "The Clinical Impact of a Quarter Century of Cancer Research." The speakers will attempt to emphasize the research developments which have clinical application today.

Further information may be obtained by writing Dr. Roald N. Grant, American Cancer Society, 521 West 57th Street, New York 19, New York.

Dr. William K. Marple New President Of W. Va. Acad., Oph. & Otol.

Dr. William K. Marple of Huntington was elevated to the presidency of the West Virginia Academy of Ophthalmology during the 15th annual meeting of that organization at The Greenbrier in White Sulphur Springs, April 23-25.

Speakers at the 15th annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology at The Greenbrier, April 23-25, included (left to right), Dr. Kelvin A. Kasper of Philadelphia; Dr. Frank D. Costenbader of Washington, D. C.; Dr. Ramon Castroviejo of New York City; and Dr. Fred R. Guilford of Houston, Texas.

He succeeds Dr. Albert C. Esposito of Huntington. Other new officers are as follows:

Dr. James T. Spencer of Charleston, president elect; Dr. R. Alan Fawcett, Wheeling, vice president; and Dr. Worthy W. McKinney of Beckley, secretary-treasurer.

Drs. Ralph W. Ryan of Morgantown and Edwin M. Shepherd of Charleston were named directors. Two past presidents, Doctor Esposito of Huntington and Dr. John A. B. Holt of Charleston, were named members of the Executive Committee.

During the business session, the Academy passed a resolution unanimously endorsing the Kerr-Mills Law and also reaffirmed their opposition to the King-Anderson Bill which is now pending in Congress.

Nearly 200 persons attended the three-day meeting, including physicians for many of the eastern states and Canada.

The scientific program included papers presented by the following guest speakers:

Drs. Kelvin A. Kasper of Philadelphia, Ramon Castroviejo of New York City, Fred R. Guilford of Houston, Texas, and Frank D. Costenbader of Washington, D. C.

Mr. Philip Salvatori, a representative of Obrig Laboratories of Sarasota Florida, demonstrated advance techniques of contact lens fitting and discussed problem cases including keratoconus and aphakia.

The 16th annual meeting of the Academy will be held at The Greenbrier in White Sulphur Springs, April 17-20, 1963.

It was also announced that a meeting of the Academy would be held at The Greenbrier on Friday afternoon, August 24, during the Annual Meeting of the West Virginia State Medical Association. The guest speaker will be Dr. Alfred E. Maumenee of Baltimore, who is Professor of Ophthalmology at Johns Hopkins University School of Medicine.

Philadelphia Radiologist Speaker At Meeting in Clarksburg

A meeting of the West Virginia Radiological Society was held at the Stonewall Jackson Hotel in Clarksburg, May 5-6. Dr. Hubert A. Shaffer of Morgantown, the president, presided at the meeting which was attended by 18 members and guests.

The principal speaker was Dr. E. M. DeYoung, radiologist at the University of Pennsylvania School of Medicine in Philadelphia. His subject was "Infantile Hip Dysplasia and Sequellae."

The following physicians were elected to membership in the Society: Drs. A. J. Barger of Glen Dale, W. Alva Deardorff of Charleston, Joseph G. Doboy of Fairmont, Raymond A. Harron of Bridgeport, Charles T. Lenton of Wheeling, J. R. McProuty of Morgantown, and Ilona Scott of Ronceverte.

The next meeting of the Society will be held at The Greenbrier in White Sulphur Springs on August 24, during the annual meeting of the West Virginia State Medical Association.

Dr. James D. Murphy Installed As AAGP President

Dr. James D. Murphy of Ft. Worth, Texas, was installed as president of the American Academy of General Practice during the annual scientific assembly in Las Vegas, April 9-12.

Dr. Albert E. Ritt of St. Paul, Minnesota, was named president elect and Dr. Herbert W. Salter of Cleveland was reelected vice president. Named to three-year terms as directors were Drs. R. Varian Sloan of Honolulu, Hawaii, Richard R. Chamberlain of Maplewood, New Jersey, and Francis L. Land of Ft. Wayne, Indiana.

Dr. Carroll L. Witten of Louisville, Kentucky, and Dr. Lewis W. Cellio of Columbus, Ohio, were reelected speaker and vice speaker, respectively, of the Academy's policy-making Congress of Delegates.

Nearly 8,000 physicians and guests attended the 14th annual assembly.

Relocations

Dr. William A. Whittaker, Jr., of Point Pleasant, has moved to Waverly, Ohio, and his office address there is 330 E. North Street.

* * * *

Dr. James W. Hamilton, who has practiced in Marlinton for the past few years, has moved to Chico, California. His office address is 119 West Francis Willard Street.

Immunization Level Low Despite Plentiful Salk Supply

Although West Virginia has had the Salk vaccine in plentiful supply for more than five years, a scant 60 per cent of all persons in the state under 21 have had the recommended course of injections, State Health Director N. H. Dyer said recently. Although exact data is not available, Doctor Dyer said that immunization levels were significantly less among susceptible individuals in older age groups.

In explaining the Health Department's policy on the usage of Salk and oral vaccines in a recent issue of the agency's "State of the State's Health," Doctor Dyer warned that the possibility of an epidemic still exists because of low levels of immunization. He said that most authorities agree "we should reach at least 80 per cent of the susceptible population to break the chain of infection."

Suggests Priorities

He advocated continued routine usage of the Salk vaccine. When available, however, he suggested that the oral vaccine be administered according to the following priorities:

1. Epidemic Control: Whenever epidemic poliomyelitis threatens an area immediate mass use of type specific monovalent oral polio vaccine should be initiated. A reserve of oral vaccine for this purpose is being maintained by the Public Health Service and allocations from this supply may be made upon request by State Directors of Health.

2. Infants: All communities should organize programs of polio immunization directed to the goal of completing the recommended immunization schedule for all infants by the time they reach their first birthday.

3. Preschool Children: Effective programs should be organized to reach all preschool children not yet fully immunized. Completion of the schedule of formaldehyde-inactivated vaccine or initiation of a full course of the oral vaccine may be chosen.

4. Other Unimmunized Groups: Older population groups, particularly young adults and parents of small children, should be encouraged to receive immunization.

Doctor Dyer emphasized that the usage of the oral vaccine should be on a community-wide basis. Also, inasmuch as enteric viruses may interfere with the effectiveness of the oral vaccine, usage should be confined to winter, spring and fall months, except in the face of a threatened epidemic.

Risk Cannot Be Equated

In another issue of the publication the health director noted that there was widespread disagreement among authorities on the possible adverse effects of radiation from fallout and that some segments of the population "become alarmed over any and all information released on the subject."

He termed as "deplorable" acts by unqualified individuals or groups who urge curtailment of milk consumption.

The risk involved through consumption of small amounts of radioactivity in milk against the risk of disruption of established dietary patterns, particularly in infants and children, cannot be equated, the state health official asserted.

Doctor Dyer explained that much of the concern surrounding radioactivity in milk was due to its choice as a sampling medium by federal health authorities.

The executive board of the Woman's Auxiliary to the West Virginia State Medical Association held its annual Spring meeting and conference at the Stonewall Jackson Hotel in Clarksburg, April 10-11. Officers attending included, left to right (seated), Mrs. Andrew J. Weaver of Clarksburg, treasurer; Mrs. Howard G. Weiler of Wheeling, president elect; Mrs. Vernon L. Dyer of Petersburg, president; and Mrs. J. A. B. Holt of Charleston, recording secretary. Standing, Mrs. L. Dale Simmons of Clarksburg, second vice president; Mrs. D. E. Greeneltch of Wheeling, parliamentarian; Mrs. Lee F. Dobbs of Huntington, fourth vice president; and Mrs. John W. Hash of Charleston, first vice president.

'The Adolescent' Subject of Seminar At Medical Center, June 28-29

The State Department of Health, through its Division of Maternal and Child Health, and the State Department of Welfare, through its Division of Crippled Children's Services, will co-sponsor the 1962 Seminar on Growth and Development—"The Adolescent," which will be held at the West Virginia University Medical Center in Morgantown, June 28-29.

Madeleine E. Morcy, M. D.

The meeting will be called to order at 9:30 A.M. on Thursday, June 28, by Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine, and an address of welcome will be delivered by W. Bernard Smith, Commissioner of the State Department of Welfare.

Dr. N. H. Dyer, Director of the State Department of Health, will present a paper on "Current Concepts of Growth and Development."

The keynote address will be delivered by Dr. Madeleine E. Morcy, of Charlottesville, Virginia, Regional Medical Director, Children's Bureau, Region III. Her subject will be "The Adolescent—A Profile of the Future."

Doctor Morcy, who received her M. D. degree from New York Medical College, practiced her specialty of pediatrics in New York City for several years and was on the staffs of several hospitals in that city.

She served as District Health Officer in New York City and also as Pediatric Consultant for the State Health Department in North Carolina. She joined the Children's Bureau as Regional Medical Director in the Chicago region in 1953 and served for several years prior to assuming her present duties in Charlottesville.

Thursday Afternoon, June 28

The program for the remainder of the two-day meeting will be as follows:

1:30—Maturation of the Adolescent."—Felix Heald, M. D., Director of the Adolescent Unit, Children's Hospital, Washington, D. C.

2:15—"Cultural and Social Development as Related to the Adolescent."—Miss Doris Crozier, Professor of Anthropology, Danberry State Teachers College, Danberry, Connecticut.

3:15—"Community Responsibility to the Adolescent Who is Mentally Retarded."—Rudolf P. Hormuth, Specialist in Services for Mentally Retarded Children, Division of Health Services, Children's Bureau, Department of Health, Education and Welfare, Washington, D. C.

4:00—Discussion Period.

Friday Morning, June 29

9:00—"Juvenile Delinquency."—C. Donald Robertson, Attorney General, State of West Virginia, Charleston.

9:45—"Youth Fitness."—Dean Ray Duncan, School of Physical Education and Athletics, West Virginia University, Morgantown.

10:45—"Counseling of the Adolescent and His Parents."—Sidney L. Werkman, M. D., Associate Director, Department of Psychiatry, Children's Hospital, Washington, D. C.

11:30—Discussion Period.

Friday Afternoon, June 29

1:30—"Adolescent Parenthood."—Nicholas W. Fugo, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, West Virginia University School of Medicine, Morgantown.

2:15—"Hospital Care of the Adolescent."—Speaker to be Announced.

2:45—Discussion Period.

The following persons will serve as moderators during the two-day Conference:

Dr. Clark K. Sleeth, Dean, West Virginia University School of Medicine; Dr. M. A. Viggiano, Health Officer, Monongalia County; Mr. H. Ward Nicklin, Administrator, District No. 4, Department of Welfare, Martinsburg; and Mrs. Mae S. Straton, Assistant Chief, Division of Crippled Children's Services, Department of Welfare.

The Seminar will bring together health personnel, educators and social agency workers of West Virginia. At the suggestion of Doctor Morcy, health and welfare leaders of the other states in Region III, Children's Bureau, have been invited.

Dr. N. H. Dyer, State Director of Health, said that all physicians in the State are invited to attend and may contact his office for further information.

Need a Physician?

Communities in rural areas in West Virginia that are interested in securing a physician may have their requests published in the classified section of *The West Virginia Medical Journal*. Interested persons should submit the population of the area in which the physician is needed and send along a descriptive sentence of their requirements and advantages of practice.

Such information will be published in *The Journal* in the hope that physicians in the state may have medical colleagues who might be interested in the practice of rural medicine in West Virginia.

A listing of physicians wishing to locate in West Virginia will also be published, provided they submit their qualifications to the headquarters offices of the State Medical Association. This service will be provided to communities and physicians without charge.

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SEARLE

Research in the Service of Medicine

WVU Medical Center
—News—

THE West Virginia University School of Medicine recently received $14,374.64 from the American Medical Association Education and Research Foundation, which was established in 1951 by the American Medical Association.

Dr. D. E. Greeneltch of Wheeling, president of the West Virginia State Medical Association, presented the check to Dean Clark K. Sleeth during a ceremony held at the Medical Center in Morgantown on May 1.

The grant is part of $1,303,161.10 contributed by physicians during 1961 to the medical schools throughout the country through the Foundation. Of the total amount, $202,219.27 was raised through the efforts of the AMA Woman's Auxiliary. The total is the largest amount contributed to the Foundation in a single year.

The West Virginia University School of Medicine recently received a check for $14,374.64 from the American Medical Education and Research Foundation. Presentation of the check to Dr. Clark K. Sleeth, right, Dean of the School of Medicine, was made by Dr. D. E. Greeneltch of Wheeling, president of the State Medical Association.

Deans of individual medical schools may use the money at their discretion for special projects or expenses outside their budgets.

Dean Sleeth said the grant will be used to strengthen the educational and research programs of the School.

- **Compiled from material furnished by Cletis Pride, Public Information Officer, West Virginia University Medical Center, Morgantown, W. Va.**

He called it a "concrete illustration of the continuing interest of practitioners in assisting medical education and research.

"The administration, faculty and students of the School of Medicine join in expressing our thanks to the many physicians' wives, particularly those of West Virginia who have specifically designated their contributions for our school, for their thoughtful support of medical education," Dean Sleeth said.

The AMA established the program so physicians could play a greater part in financial support of medical schools. Money contributed to AMA-ERF may be designated for a specific medical school. All money not designated is divided equally among the 86 schools.

Physicians have given more than eleven and one half million dollars to medical schools through the Foundation since it was created.

During 1962, the Foundation is attempting to raise funds to assist in the financing of medical scholarships and for loans for medical students, as well as to physicians in internships and residencies.

School of Medicine Accredited

The West Virginia University School of Medicine has been accredited as a four-year school. The recent announcement followed a thorough study of the school's facilities, personnel and educational program last fall by a liaison committee of the Council on Medical Education and Hospitals of the American Medical Association and the Executive Council of the Association of American Medical Colleges.

It means that this year's class—the first to receive M. D. degrees in West Virginia—will be graduated by a fully accredited medical school. The School of Medicine previously was accredited on the basis of its two-year program.

A four-man committee visited the School of Medicine last October, and a 68-page report on the results of the visit was the basis for accreditation.

Dean Clark K. Sleeth said the School of Medicine is "extremely gratified" with the findings of the liaison team. "Their specific recommendations and findings will be of great help to the University in further strengthening the School of Medicine," he added.

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spasm is

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Low back pain and other skeletal muscle spasms are tractable disorders when you treat them with Trancopal, the relaxant that quickly eases the spasm and gets the muscle moving. You have a more tractable patient with Trancopal, too —its mild tranquilizing action makes him less irritable, better able to bear his discomfort, more willing to cooperate in physiotherapy.

These two complementary actions of Trancopal are commented on in many recent reports; e.g., Kearney[1] states: "...Trancopal has proven to be an extremely effective striated muscle relaxant and subcortical tranquilizer." Cornbleet,[2] discussing the use of Trancopal in dermatologic practice, comments: "Noteworthy was the soothing effect of chlormezanone without interference with normal activities or alertness... Patients were found more tractable and easier to control."

Marks[3] found that in patients with backache "...Trancopal offered considerable relief by alleviating both apprehension as well as musculoskeletal discomfort." Hergesheimer[4] comments: "...Trancopal acts to reduce the initial painful spasm and to allay anxiety, resulting in a cooperative patient whose subsequent recovery and return to work is accomplished more quickly."

Available: 200 mg. Caplets® (green colored, scored), 100 mg. Caplets (peach colored, scored), each in bottles of 100. **Dosage:** Adults, 200 mg. three or four times daily; children (5 to 12 years), from 50 to 100 mg. three or four times daily.

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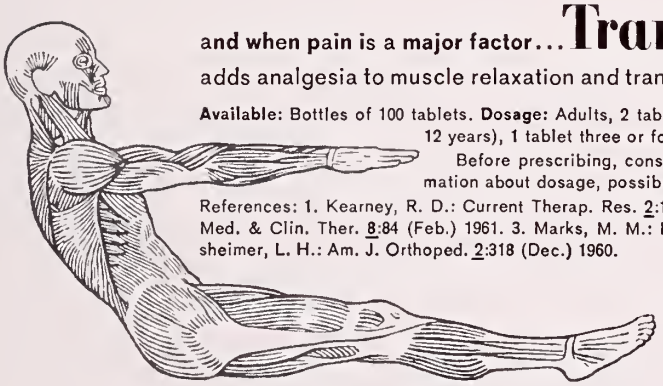
ASPIRIN (5 GRAINS) 300 MG.
TRANCOPAL ..... 50 MG.

adds analgesia to muscle relaxation and tranquilization

Available: Bottles of 100 tablets. **Dosage:** Adults, 2 tablets three or four times daily; children (5 to 12 years), 1 tablet three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. Kearney, R. D.: Current Therap. Res. 2:127 (April) 1960. 2. Cornbleet, T.: Antibiotic Med. & Clin. Ther. 8:84 (Feb.) 1961. 3. Marks, M. M.: Missouri Med. 58:1037 (Oct.) 1961. 4. Hergesheimer, L. H.: Am. J. Orthoped. 2:318 (Dec.) 1960.



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The Month in Washington

• **From the Washington Office of the American Medical Association.**

Top officials of the American Medical Association at a White House conference with President Kennedy stood pat in support of the Kerr-Mills program and in opposition to providing health care for the aged under social security. President Kennedy also maintained his position that the social security mechanism should be used.

Using Boisfeuillet Jones, special assistant to the Secretary of Health, Education and Welfare as an intermediary, President Kennedy invited the AMA officials to the White House just before the Administration started an all-out effort to get Congressional approval of legislation that would provide limited hospitalization and some other health care to older persons under social security.

The House Ways and Means Committee, which rejected the social security approach in 1960, is expected to vote on similar legislation again this year.

White House 'Lobby' Office

In its campaign for the King-Anderson bill, which utilizes the social security system, the Administration and its allies called rallies of aged persons, exerted pressures through a White House "lobby" office, published a propaganda pamphlet at taxpayers' expense and had federal employees drumming up support for the proposal.

Following the 45-minute White House session with President Kennedy, Dr. Leonard W. Larson of Bismarck, North Dakota, AMA president, said the AMA representatives made clear that the great majority of the nation's physicians oppose the King-Anderson bill or similar legislation. Doctor Larson also said the Administration is wrong in its statements that such legislation will be approved by Congress.

"We have a very good line of communication with the grass roots and the support of the old people for the Administration plan is decreasing now that they realize what it will mean to them," Doctor Larson said.

Doctor Larson charged that the Kennedy Administration is "trying to create a bandwagon" for its medical care for the aged program. He said "the propaganda indicates the Administration is not getting the support it needs for its bill, and we are convinced the trend is the other way."

In addition to Doctor Larson, AMA officials at the White House were: Dr. Hugh H. Hussey, Jr., of Washington, D. C., chairman, AMA Board of Trustees; Dr. Percy E. Hopkins of Chicago, vice chairman, AMA Board of Trustees; Dr. Norman Welch of Boston, speaker, AMA House of Delegates; Dr. Edward R. Annis of Miami, Florida, chairman, AMA National Speakers Bureau; Dr. F. J. L. Blasingame of Chicago, AMA executive vice president, and Dr. Ernest B. Howard of Chicago, AMA assistant executive vice president.

'Honest Interchange of Divergent Views'

Doctor Annis said the meeting "was an honest interchange of divergent views on the method of providing medical care for the senior citizens of our country." He said the AMA position was that when the government provided for people in need, this was "a proper manifestation of the Christian-Judaic consideration for fellow man."

But when the government provides for everyone under a system of forced contributions this amounts to socialized medicine, Doctor Annis said.

On other health matters, President Kennedy expressed interest in the AMA-sponsored First National Congress on Mental Health this fall. He said he hoped to be able to accept an AMA invitation to present an address. He also noted several legislative and other items in which there was substantial agreement between the AMA and the Administration, including aid for construction of medical schools and establishment of the health resources advisory committee.

Shortly after the White House meeting, Republican senators met and agreed to hold firm in support of the Kerr-Mills bill and against King-Anderson. They refused to endorse any substitute.

One of the prime tactics of the Administration has been to give the impression that the King-Anderson bill enjoys wide public support. However, congressional polls of more than 450,000 voters revealed just the opposite with increasing public opposition evident toward the disputed plan. Of 43 polls taken during the current Congress 28 showed strong popular sentiment against the bill. The latest 16 polls ran 12 to 4 against it.

The American Dental Association reiterated opposition to the King-Anderson bill. An editorial in the ADA Journal stated "participation in a government-sponsored program of health care should be voluntary." ADA secretary Dr. Harold Hillenbrand called the bill "election time propaganda."

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Iron *(Ferrous Betaine Citrate)*	30 mg.
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Manganese *(Manganese Betaine Citrate)*	1 mg.
Zinc *(Zinc Betaine Citrate)*	1.25 mg.
Magnesium *(Magnesium Betaine Citrate)*	6 mg.

5 B-COMPLEX VITAMINS

Vitamin B_1	1.5 mg.
Vitamin B_2	1.2 mg.
Vitamin B_{12}	6 mcg.
Niacin	10 mg.
Panthenol	10 mg.

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Annual Audit, 1961

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1961 has been completed by the firm of Fitzhugh, Erwin, McKee and Hickman, Certified Public Accountants of Charleston. The complete audit, with letter of transmittal, follows:

FITZHUGH, ERWIN, McKEE & HICKMAN
Certified Public Accountants
Kanawha Banking & Trust Building
Charleston 1, W. Va.

West Virginia State Medical Association
Charleston, West Virginia

We have examined the receipts and disbursements of your Association for the year ended December 31, 1961. Summary statements of the various funds which were prepared from your records and a schedule of bonds owned at the year end are presented herewith.

Cash in bank amounting to $36,853.23 at December 31, 1961, was reconciled with the balance confirmed by the depository bank and bonds owned by your Association at that date were verified by inspection at the safe deposit box on April 19, 1962.

In December, 1961, a pension plan, as authorized by the council, was placed in effect for the exclusive benefit of all eligible employees of the Association. The cost of this plan will be borne 75% by the Association and 25% by the participating employees.

The premium for the year 1962 in the amount of $1,683.05 was paid in December, 1961. The employee portion of this premium is being withheld in equal amounts from the periodic compensation of each participating employee.

In our opinion, all receipts of record of the West Virginia State Medical Association for the year ended December 31, 1961 have been properly accounted for and the balance in bank and bonds owned at December 31, 1961 are correctly stated herein.

FITZHUGH, ERWIN, McKEE & HICKMAN

Charleston, W. Va.
April 26, 1962

COMBINED STATEMENT OF RECEIPTS AND DISBURSEMENTS CALENDAR YEAR 1961

CASH IN BANK—JANUARY 1, 1961		$ 40,742.19
RECEIPTS		
Dues	$ 37,143.50	
Interest on U. S. Bonds	800.00	
Collection Commission on A.M.A. Dues	320.49	
Advertising	33,215.71	
Emblems sold	61.75	
Extra cuts in journal	62.00	
Subscriptions	955.50	
Exhibit space sold	5,685.00	
Dues collected for A.M.A.	28,475.00	
Medical Scholarship Fund Assessment	3,491.50	
Contributions to Medical Scholarship Fund	4,055.00	
Refunds	685.09	
Total Receipts		114,950.54
		155,692.73
DISBURSEMENTS		
General Fund	39,704.78	
Medical Journal Fund	34,590.90	
Convention Fund	11,811.67	
Dues forwarded to A.M.A.	28,475.00	
Medical Scholarship Fund	3,588.13	
Public Relations Fund	669.02	
Total Disbursements		118,839.50
CASH IN BANK—DECEMBER 31, 1961		$ 36,853.23

GENERAL FUND
Statement of Receipts and Disbursements
Calendar Year 1961

BALANCE—JANUARY 1, 1961		$ 21,558.73
RECEIPTS		
Dues (Allocated to General Fund)	$ 37,143.50	
Interest on U. S. Bonds	650.00	
Collection Commission on A.M.A. Dues	320.49	
Refunds—Convention	24.44	
A.M.A. Dues	50.00	
Total Receipts		38,188.43
		59,747.16

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DISBURSEMENTS		
Salaries (Less payroll taxes)		
Executive secretary	6,371.80	
Office	8,044.01	
Office supplies and expense	2,813.02	
Office rent	3,180.00	
Library expense	234.41	
Telephone and telegraph	1,862.85	
Postage	1,550.55	
Travel	2,511.16	
Refunds—A.M.A. Dues	25.00	
Dues	60.00	
Payroll taxes	4,946.44	
Unemployment tax	459.14	
Mimeographing	1,379.72	
Expense of Council and Committee Meetings	2,097.31	
Miscellaneous expense	2,486.32	
Employee Benefit Plan (See letter)	1,683.05	
Total Disbursements		39,704.78
BALANCE—DECEMBER 31, 1961		$ 20,042.38

MEDICAL JOURNAL FUND

Statement of Receipts and Disbursements Calendar Year 1961

BALANCE—JANUARY 1, 1961		$ 7,540.44
RECEIPTS		
Advertising	$ 33,215.71	
Emblems sold	61.75	
Subscriptions	955.50	
Extra cuts in articles	62.00	
Total Receipts		34,294.96
		41,835.40
DISBURSEMENTS		
Printing	25,184.16	
Engraving	937.90	
Postage	671.00	
Salaries and editing	6,588.82	
Travel	124.00	
Refund of subscription	3.50	
Clippings	519.38	
Telephone	188.00	
Miscellaneous	374.14	
Total Disbursements		34,590.90
BALANCE—DECEMBER 31, 1961		$ 7,244.50

CONVENTION FUND

Statement of Receipts and Disbursements Calendar Year 1961

BALANCE—JANUARY 1, 1961		$ 5,839.58
RECEIPTS		
Exhibit space sold	$ 5,685.00	
Refunds—		
Convention Golf Tournament	220.00	
Travel expense	370.65	
Others	20.00	
Total Receipts		6,295.65
		12,135.23
DISBURSEMENTS		
Supplies and labor	4,896.90	
Travel	1,616.35	
Entertainment	3,816.61	
Telephone and telegraph	429.80	
Advance, Convention Golf Tournament	230.00	
Reporting	214.75	
Miscellaneous	192.86	
Auxiliary Convention expense	250.00	
Printing	164.40	
Total Disbursements		11,811.67
BALANCE—DECEMBER 31, 1961		$ 323.56

AMERICAN MEDICAL ASSOCIATION DUES

Statement of Receipts and Disbursements Calendar Year 1961

BALANCE—JANUARY 1, 1961	None
RECEIPTS	
Dues collected for A.M.A.	$ 28,475.00
	28,475.00

Coca-Cola, too, is compatible with a well balanced diet. As a pure, wholesome drink, it provides a bit of quick energy ... brings you back refreshed after work or play. It contributes to good health by providing a pleasurable moment's pause from the pace of a busy day.

DRINK Coca-Cola TRADE-MARK ®

DISBURSEMENTS	
Dues forwarded to A.M.A.	28,475.00
BALANCE DUE A.M.A.—DECEMBER 31, 1961	$ None

PUBLIC SERVICE FUND

Statement of Receipts and Disbursements Calendar Year 1961

BALANCE STATE ASSESSMENTS—JANUARY 1, 1961		$ 1,966.67
RECEIPTS		
Assessments		None
		1,966.67
DISBURSEMENTS		
Conference and general expense	$ 605.66	
Printing	58.36	
Bulletins and expense	5.00	
Total Disbursements		669.02
BALANCE STATE ASSESSMENTS—DECEMBER 31, 1961		$ 1,297.65

MEDICAL SCHOLARSHIP FUND

Statement of Receipts and Disbursements Calendar Year 1961

BALANCE—JANUARY 1, 1961		$ 3,836.77
RECEIPTS		
Assessments	$ 3,491.50	
Contributions	4,055.00	
Interest on U. S. Treasury Bonds	150.00	
Total Receipts		7,696.50
		11,533.27
DISBURSEMENTS		
Scholarship installment	3,500.00	
Travel, printing and miscellaneous expense	88.13	
Total Disbursements		3,588.13
BALANCE—DECEMBER 31, 1961		$ 7,945.14

SCHEDULE OF BONDS OWNED AS OF DECEMBER 31, 1961

	Serial	Due Date	Maturity Value
U. S. Treasury 2½%	27070L	12-15-67/72	$10,000.00
U. S. Treasury 2½%	27846F	12-15-67/72	10,000.00
U. S. Treasury 2½%	70011A	12-15-67/72	1,000.00
U. S. Treasury 2½%	70012B	12-15-67/72	1,000.00
U. S. Treasury 2½% (Sp. Fund)	72361A	12-15-67/72	1,000.00
U. S. Treasury 2½%	19534D	12-15-67/72	500.00
U. S. Treasury 2½%	20707H	12-15-67/72	500.00
U. S. Treasury 2½%	20935E	12-15-67/72	500.00
U. S. Treasury 2½%	21421A	12-15-67/72	500.00
U. S. Treasury 2½%	21914D	12-15-67/72	500.00
U. S. Treasury 2½%	22646F	12-15-67/72	500.00
U. S. Treasury 2½% (Medical Scholarship Fund)	6873C	9-15-67/72	5,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	18939K	9-15-67/72	1,000.00
Series "J"	Q22297J	1-1-1968	25.00
Series "J"	Q22298J	1-1-1968	25.00
Total			$ 32,050.00

COMPARATIVE SCHEDULE OF CASH AND BONDS AS OF DECEMBER 31, 1960 and 1961

CASH	12-31-60	12-31-61	Increase (Decrease)
General Fund	$21,558.73	$20,042.38	($ 1,516.35)
Medical Journal Fund	7,540.44	7,244.50	(295.94)
Convention Fund	5,839.58	323.56	(5,516.02)
A.M.A. Dues			
Public Service Fund	1,966.67	1,297.65	(669.02)
Medical Scholarship Fund	3,836.77	7,945.14	4,108.37
Total Cash	40,742.19	36,853.23	(3,888.96)
U. S. BONDS (at cost)	31,144.91	31,144.91	
TOTAL CASH AND BONDS	$71,887.10	$67,998.14	($ 3,888.96)

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A. J. Berlow, M. D

Ophthalmology:
Robert A. Dye, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Barbara Karrer, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
JoAnn Hastings
Roentgenology:
Evelyn Forester, R. T.

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John H. Clark, Manager
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Each capsule contains:	
Vitamin B_1 (Thiamine Mononitrate)	10 mg
Vitamin B_2 (Riboflavin)	10 mg
Niacinamide	100 mg
Vitamin C (Ascorbic Acid)	300 mg
Vitamin B_6 (Pyridoxine HCl)	2 mg
Vitamin B_{12} Crystalline	4 mcgm
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily or as directed by physician, for the treatment of vitamin deficiencies.

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ACTIVE INGREDIENTS: Sodium lauryl sulfate, sodium perborate, sodium borate, thymol, eucalyptol, menthol, methyl salicylate. AVAILABLE: In jars of 5, 12 and 20 oz. powder. REFERENCES: 1. Stepto, R. C., and Guinant, D.: J. Nat. M.A. 53:234, 1961. 2. Karnaky, K. J.: Medical Record and Annals 46:296, 1952. 3. Folsome, C. E.: Personal Communication. 4. MacDonald, E. M., and Tatum, A. L.: J. Immunology 59:301, 1948.

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Obituaries

WILLIAM WARD CURRENCE, M. D.

Dr. William Ward Currence, 48, of South Charleston, died on May 6 while fighting a brush fire at his farm in Mason County. Death resulted from suffocation caused by smoke inhalation.

Doctor Currence, who was a native of Clarksburg, had practiced in South Charleston since 1953. He was graduated from Virginia Military Institute and attended the two-year School of Medicine at West Virginia University. He received his M. D. degree from the University of Maryland School of Medicine in 1942.

He interned at Letterman Army Hospital in San Francisco, 1942-43, after being commissioned a First Lieutenant in the Medical Corps of the United States Army. He served residencies at Walter Reed General Hospital, Colorado General Hospital and Fitzsimons General Hospital.

He was released from the Army in 1950 with the rank of Lieutenant Colonel. During his tour of duty, Doctor Currence was awarded the Bronze Star and Commendation Ribbon.

Doctor Currence was certified by the American Board of Pediatrics in 1951 and was serving as secretary of the West Virginia Pediatric Society at the time of his death. He had served for nearly a decade as consultant to the Division of Maternal and Child Health, State Health Department, and was a member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a daughter, Mary Alice, a student at West Virginia University; two sons, William and Philip, both at home; and a sister, Mrs. Henry Snyder of Sistersville.

* * * *

VICTOR L. GLOVER, M. D.

Dr. Victor L. Glover, 74, of Martinsburg, died on May 4 at a hospital in that city.

Doctor Glover, who was a native of Martinsburg, had been actively engaged in practice there since 1918. He was graduated from Shepherd College and Ohio State University, and he received his M. D. degree from the University of Maryland School of Medicine in 1914.

He was licensed to practice in West Virginia that same year and located at Inwood, Berkeley County. In 1915, he was named assistant medical advisor at the Crownsville State Hospital in Maryland.

During World War I, Doctor Glover served in the Medical Corps of the United States Army and was discharged with the rank of First Lieutenant.

Doctor Glover served for many years as team physician at the high schools in Martinsburg and Musselman. He was a member of the Eastern Panhandle Medical Society, West Virginia State Medical Association and American Medical Association.

His only survivor is his wife, Mrs. Vallie Cook Glover.

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Organon's new technical process now makes one of the newer, most highly potent and well tolerated corticosteroids available at greatly reduced cost to your patients with allergic, arthritic or other inflammatory conditions.

This new product is being marketed under the trade name of HEXADROL, brand of dexamethasone 'Organon'. HEXADROL is now being offered to your pharmacist at a price which should make it available to your patients at a cost well within the price range of older generically prescribed corticosteroids. It is supplied as 0.75 mg. white scored tablets, in bottles of 100.

If you have been prescribing the older corticosteroids— such as prednisone, prednisolone, hydrocortisone or cortisone, and have hesitated to prescribe the newer corticosteroids because of economic consideration for your patients, you can now secure all of the clinical advantages of dexamethasone at approximately the same prescription expense. Mg. for mg., HEXADROL is approximately 6 times more potent than triamcinolone or methylprednisolone... 8 times more potent than prednisone or prednisolone... 28 times more potent than hydrocortisone... and 35 times more potent than cortisone.

If you are now prescribing the newer corticosteroids— such as triamcinolone, betamethasone, paramethasone or another brand of dexamethasone, because of reduced risk of sodium and fluid retention, potassium depletion, or disturbance of glucose metabolism—you can obtain all of these benefits with HEXADROL, at marked savings—yet with complete assurance of unsurpassed quality and therapeutic effect.

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REDI-SWABS is a swab impregnated with benzethonium 1/1000, Isopropanol 50%. Adequate research has been done to assure the user that it is an effective sterilizing medium for skin sterilization. They are packed 100 in plastic jar with sufficient extra solution supplied to supplement any evaporation due to negligence. 10 jars to a carton. Price per carton of 1000 ..... **$4.95**

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HUNTINGTON, WEST VIRGINIA

County Societies

BARBOUR-RANDOLPH-TUCKER

Dr. Dean R. Goplerud of Morgantown was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker County Medical Society which was held at the Philippi Inn on April 19.

Doctor Goplerud, who is an Instructor in Obstetrics and Gynecology at the West Virginia University School of Medicine, discussed "Pregnancy Complicated by Heart Disease."

He stated that the incidence of heart disease occurring in pregnancy was between 1.7-3.7 per cent, of which 90 per cent was due to rheumatic fever. He said that during the first trimester a decision regarding continuation of pregnancy should be made. If allowed to continue, he said, management consists of extra rest, restricted weight gain, liberal use of hospitalization and consultation with a cardiologist.

During the business meeting, Drs. G. E. Hartle and R. C. Gow were elected to membership in the Society.

Dr. Charles L. Leonard, Chairman of the Public Relations Committee, presented a report on the advertising campaign in opposition to enactment of the King-Anderson Bill.

Twenty two members attended the meeting.—A. Kyle Bush, M. D., Secretary.

Radiology:
KARL J. MYERS, M. D.

Clinical Pathology:
E. E. MYERS, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Anatomic Pathology:
S. D. WU, M. D.

Dentistry:
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KANAWHA

Dr. George E. Plum of Rochester, Minnesota, was the guest speaker at the regular monthly meeting of the Kanawha Medical Society which was held at the Daniel Boone Hotel in Charleston on May 8.

Doctor Plum, who is a member of the staff of the Mayo Clinic, presented an interesting paper on "Coronary, Renal and Cerebral Angiography."

Drs. James H. Nelson of Charleston and E. D. Staats of Ripley were elected to membership in the Society.

* * * *

MERCER

Dr. D. E. Greeneltch of Wheeling, President of the West Virginia State Medical Association, delivered an interesting address at the regular monthly meeting of the Mercer County Medical Society which was held at the University Club in Bluefield on April 16.

Doctor Greeneltch, introduced by Dr. Joe E. McCary, the president, discussed the cutback last fall in the MAA program by the State Welfare Department. He said the proposed King-Anderson legislation, supported by the administration, would be a wedge in the door of the socialism of medicine.

Dr. Henry F. Warden, Jr., member of the MAA District 5 Review Committee, discussed proposed uniform charges for injections.

Dr. Wallace Duncan was unanimously elected to membership in the Society. The Society also voted to contribute $25 to Camp Kno-Koma, a summer camp for diabetic children.—John J. Mahood, M. D., Secretary.

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MONONGALIA

Dr. William Cooper, chief of hematology at the Pittsburgh Diagnostic Clinic, presented an interesting paper on the "Theory of Leukemia and Lymphomas" at the regular monthly meeting of the Monongalia County Medical Society in Morgantown on April 3.

Dr. C. Truman Thompson, the president, presided at the meeting which was attended by 44 members and six guests.

A proposal by Dr. W. E. King to have the Society sponsor a community information program was approved. Appointed to the information committee by Doctor Thompson were Drs. Reginald F. Krause, Robert J. Fleming, Ralph W. Ryan, E. F. Hciskell, Jr., Charles S. Mahan and W. E. King.

Doctor Thompson and Drs. Carl E. Johnson, C. A. Logue, George A. Curry and John H. Trotter, members of the executive committee, also will serve on the information committee.—George A. Curry, M. D., Secretary.

1984 Is Approaching Fast Enough

The American pharmaceutical industry has served this country and the world very well, and still is. And the present powers of the FDA are quite adequate. And free enterprise is still preferable to medication according to the wisdom of Mr. Ribicoff or any of his probable successors. 1984 is approaching fast enough; let's not hurry it!—Hawaii Medical Journal.

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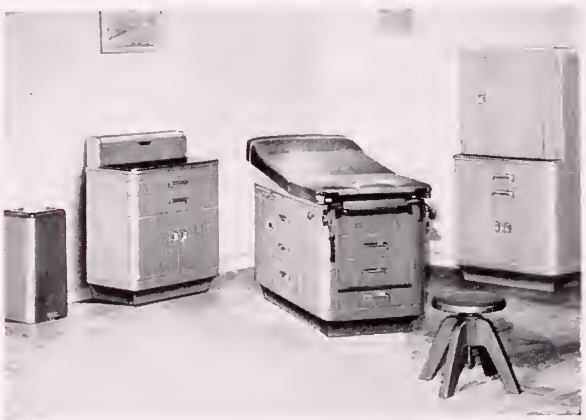

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The Eau Claire Hotel

ATLANTA, GEORGIA
Wednesday, July 18, 1962
The Hotel Dinkler Plaza

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CLARKSBURG, WEST VIRGINIA
Sunday, September 9, 1962
The Stonewall-Jackson Hotel

TYLER, TEXAS
Wednesday, September 12, 1962
Carlton Hotel

KANSAS CITY, KANSAS
Friday, September 14, 1962
Battenfeld Auditorium

WOODSTOCK, VERMONT
Wednesday, September 19, 1962
The Woodstock Inn

NIAGARA FALLS, ONTARIO
Saturday, September 29, 1962
Sheraton-Brock Hotel

RAPID CITY, SOUTH DAKOTA
Saturday, October 6, 1962
Holiday Inn

FINDLAY, OHIO
Thursday, October 11, 1962
The Findlay Country Club

HONOLULU, HAWAII
Sunday, October 21, 1962
The Princess Kaiulani Hotel

NEWARK, NEW JERSEY
Sunday, October 28, 1962
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Corresponding Secretary: Mrs. Fred Moomau, Petersburg
Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

LOGAN

Mrs. Herman W. Rannels was reelected president of the Woman's Auxiliary to the Logan County Medical Society at the April meeting which was held in the Oasis Room of the Smoke House in Logan.

Other new officers for the coming year are as follows: Mrs. Thornton A. Beckner, president elect; Mrs. Harold Van Hoose, vice president; Mrs. F. M. Viscuse, secretary; and Mrs. E. R. Chillag, treasurer.

* * * *

McDOWELL

The Annual "Health Careers Tea," sponsored by the Woman's Auxiliary to the McDowell County Medical Society, was held at the First Methodist Church in Welch on April 25. More than 100 students from seven of the nine high schools in McDowell County attended the affair.

Two girls from each high school were given questions to ask a panel of Auxiliary members composed of Mrs. W. Ralph Counts, Moderator, and Mesdames A. J. Villani, H. A. Bracey, F. L. Johnston, Stephen Mamick and Richard O. Gale.

The questions pertained to qualifications and requirements for entrance into the nursing and other allied fields. It was pointed out that the Auxiliary has established a loan fund for students who have been accepted by nursing schools.

Mrs. Ray E. Berger was in charge of arrangements and she was assisted by Mesdames Kenneth N. Byrne, R. O. Gale and Louis A. Vega.

Mrs. George L. Fischer was elected president of the Woman's Auxiliary to the McDowell County Medical Society during the regular monthly meeting which was held at the home of Mrs. Edward D. Gibson in Iaeger on May 2.

Other new officers were elected as follows: Mrs. A. A. Carr, president elect; Mrs. David J. Skewes, first vice president; Mrs. R. H. Edwards, second vice president; Mrs. F. L. Johnston, secretary; and Mrs. Louis A. Vega, treasurer.

Mrs. H. A. Bracey, the retiring president, expressed appreciation to members for their cooperation during

the past year.—Mrs. F. L. Johnston, Secretary and Publicity Chairman.

* * * *

MARION

Mrs. Paul L. Gotses was installed as president of the Woman's Auxiliary to the Marion County Medical Society during a luncheon meeting which was held at the Town House Motor Hotel in Fairmont on April 24.

Other new officers for the coming year are as follows: Mrs. William A. Ehrgott, president elect; Mrs. George T. Evans, vice president; Mrs. John D. Lindsay, Jr., secretary; and Mrs. John J. Coogle, treasurer.

Mrs. J. J. Jenkins, Jr., the retiring president, presided at the meeting. Committee appointments were made and it was announced that the annual membership meeting would be held in September.

* * * *

MERCER

Dr. Ralph E. Haynes was the guest speaker at the April meeting of the Woman's Auxiliary to the Mercer County Medical Society.

Doctor Haynes gave an interesting talk on the activities of the Mercer County Society for Crippled Children and Adults. He outlined the program of the Society and the services offered in Mercer County. He stated that interest in the Society could be furthered through the cooperation of volunteer workers.

Mrs. William F. Hillier, Jr., the president, presided at the luncheon meeting.

MINGO

Mrs. Robert J. Tchou was elected president of the Woman's Auxiliary to the Mingo County Medical Society during the regular monthly meeting which was held at the Mountaineer Hotel in Williamson.

Other new officers elected were as follows: Mrs. Clarence G. Rayburn, vice president; Mrs. Don V. Hatton, secretary; and Mrs. J. E. Johnson, treasurer.

Mrs. Lee F. Dobbs of Huntington, fourth vice president of the Woman's Auxiliary to the State Medical Association, attended the meeting and presented a report on the Auxiliary workshop held recently in Clarksburg.

Mesdames Clarence G. Rayburn and Don V. Hatton were hostesses for the luncheon meeting.

* * * *

PARKERSBURG ACADEMY

Lieutenant Commander Jack B. Rothbart was the guest speaker at the April meeting of the Woman's Auxiliary to the Parkersburg Academy of Medicine which was held at the Chancellor Hotel in Parkersburg.

Commander Rothbart, who is commanding officer of the Wheeling Naval-Marine Corps Reserve Training Center, discussed "Problems in Viet Nam." He said that that small country, which once was a land of romance, is now a state of conflict between the free world and communism. He returned recently from an 18-month tour of duty in Viet Nam and Laos.

Mrs. George Gevas, the president, presided at the meeting and the speaker was introduced by Mrs.

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Charles F. Whitaker, Jr. Mrs. Charles L. Goodhand also presented a legislative report.

* * * *

RALEIGH

Mrs. Richard G. Starr was installed as president of the Woman's Auxiliary to the Raleigh County Medical Society during a meeting held at the Glass House in Beckley on April 16.

Other new officers for the coming year are as follows: Mrs. John J. Marra, president elect; Mrs. Charles W. Merritt, vice president; and Mrs. I. Braxton Anderson, treasurer.

The speaker at the luncheon meeting was Dr. John A. Hedrick, president of the Raleigh County Medical Society. He discussed "Medical Care for the Aged" and pointed out that "the major fallacy of providing medical care for the aged under the Social Security system is that it is based on the erroneous assumption that a majority of the aged are in need of this type of care and are financially unable to meet the cost."

No Something for Nothing

When asked, "Would you favor raising taxes to pay all doctors a salary?" 80 per cent of Americans in a survey replied "No." This has been reported to the American Academy of General Practice by its executive director, Mac F. Cahal, on the basis of a study by the Opinion Research Corporation of Princeton, N. J. He said: "There is no such thing as 'free' medical care. Politicians should not use this word to deceive the American people."

Book Reviews

EARLY DETECTION AND DIAGNOSIS OF CANCER.—By Drs. Walter E. O'Donnell, Emerson Day and Louis Venet, New York City. Pp. 286, with illustrations. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis, Missouri. 1962. Price $12.00.

This book is a practical guide to the essential facts about the physical, laboratory and roentgen findings which will help a physician to detect the various types of cancer before they have progressed to a size or stage where they will produce symptoms.

The authors felt that there was a definite need for concise descriptions and explanations of the various methods for cancer detection, because none was previously available; and because they had the deep conviction that the treatment of cancer in the asymptomatic stage would substantially increase the cure rate.

They admit that certain investigators dispute the latter tenet but submit that logic is on their side. They state that they are supported in their conviction by studies which are now in progress in the Strang Clinic, Memorial Hospital for Cancer and Allied Diseases.

Chapter II of this book presents in more detail, but still in outline form, the various essential steps in a cancer detection examination. Sample history and examination forms are reproduced for the physician's guide in making his own. A number of excellent line

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Wyoming	Mrs. R. C. Hatfield	Oceana	Mrs. Ward Wylie	Mullens

drawings are used to illustrate various tests and examinations. Most of these procedures are, of course, familiar to practicing physicians but the explanations and drawings are valuable, nevertheless, in reminding the practitioner of ones he might forget in setting up his own routine for cancer detection.

The remaining chapters describe the examination of the various regions and organs of the body and also the findings in precancerous lesions and in actual malignancy.

This book is very timely and it should prove valuable to every medical student, intern, resident and practicing physician since the destruction of precancerous lesions, early diagnosis and early treatment of cancer are the chief weapons which we have against cancer at the present time.

It is stated by the American Cancer Society that of an estimated 500,000 new cancer cases in the United States in 1961, approximately 170,000 were cured. An additional 85,000 could have been cured merely by "the full and timely application of currently available methods of diagnosis without further research or advances in treatment."

This is a practical goal which we could adopt and which we should seek. This book will do much to guide us toward that end.—Hu C. Myers, M. D.

New Saunders Books

W. B. Saunders Company features the following recent books in their full-page advertisement appearing on page vii in this issue:

Green and Richmond—"Pediatric Diagnosis." A symptomatic approach to diagnosis of childhood disorders and telling you what to look for, how to look for it, and the significance of your findings.

Nealon—"Fundamental Skills of Surgery."—Step-by-step procedures in both major and minor surgery, ranging from management of infection to closed chest treatment of cardiac arrest.

The 1961-1962 Mayo Clinic Volumes—171 valuable articles from this medical center on the latest diagnosis and treatment measures in medicine and surgery.

* * * *

POSTPARTUM PSYCHIATRIC PROBLEMS—By James Alexander Hamilton, Ph.D., M. D., Associate Clinical Professor of Psychiatry, Stanford University School of Medicine, Stanford, California; Chief of Service, Psychiatry, Saint Francis Memorial Hospital, San Francisco, California. Pp. 156. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Missouri. 1962. Price $6.85.

This book is designed to serve as a guide for obstetricians and generalists in the recognition, understanding and handling of the so-called "post-partum psychosis."

While in a way helpful insofar as signs and symptoms are discussed, the author departs from standard psychiatric theory when he uses the term "post-partum psychosis" to describe the different psychiatric pictures seen in the post-partum period. It is accepted today that these reactions, e.g. schizophrenia, do not differ from any other schizophrenic reaction and that pregnancy or delivery has acted as a trigger mechanism in the same way as the loss of a relative, economic failure or family trouble may act in a non-delivering person.

Based on these facts, the APA in its classification of mental disorders excluded the term "post-partum psychosis." The author's ideas are different from this point of view and he considers these disorders as a specific entity with specific features.

Through the monograph the author stresses questionable patho-physiologic factors (such as thyroid and estrogen deficiencies, adrenal gland involvement) at the expense of neglecting the psychodynamics (i.e. motivation) of the possible illness, as well as the patient's future existence. While a drug may be useful in the initial stages of treatment it should be regarded as a secondary or temporary tool until psychotherapy can be instituted. Psychodynamics are approached in a superficial way, accepting or pointing out such symptoms as homosexuality or hostility as the *causes* and not as *expressions* of underlying problems. There is no attempt to answer the "why" questions of these pathological emotional productions. Other chapters like the one on anxiety, or EST, are too extensive to be practicable for the obstetrician or generalist.

The book has a partial limited value helping to recognize and perhaps diagnose mental disorders in the post-partum; but there is no valid reason for separate nosological entity of "post-partum psychosis" when schizophrenic reactions, manic-depressive, depressive reactions and neurosis are better clinically recognized and diagnosed.—Max Plutzky, M. D.

Books Received

PHYSICAL DIAGNOSIS—By Ralph H. Major, M. D., Professor of Medicine and of the History of Medicine, The University of Kansas; and Mahlon H. Delp, M. D., Professor of Medicine, The University of Kansas. Pp. 355, with illustrations. W. B. Saunders Company: Philadelphia and London Sixth Edition. 1962. Price $7.50.

* * * *

SHOCK: PATHOGENESIS AND THERAPY (An International Symposium Sponsored by Ciba in Stockholm, June 27-30, 1961).—Edited by K. D. Bock of Basle. Pp. 392, with 81 figures.

* * * *

TOMORROW'S MIRACLE—By Frank Slaughter, M. D. Pp. 306. Doubleday and Company, 535 Madison Avenue, New York City, New York. Price $3.95.

* * * *

CLINICAL PATHOLOGY, APPLICATION AND INTERPRETATION—By Benjamin B. Wells, M. D., Assistant Chief Medical Director for Research and Education in Medicine, Veterans Administration. Pp. 541, with illustrations. Philadelphia and London: W. B. Saunders Company. 1962. Third Edition. Price $9.00.

* * * *

A TEXTBOOK OF OBSTETRICS—By Duncan E. Reid, M. D., William Lambert Richardson Professor of Obstetrics, and Head of the Department of Obstetrics and Gynecology, Harvard University Medical School. Illustrated by Edith Tagrin. Pp. 1087. Philadelphia and London: W. B. Saunders Company. 1962. Price $18.50.

CLASSIFIED

PHYSICIAN WANTED—The citizens of Pennsboro are interested in procuring the services of a physician. Pennsboro has a population of about 2,000, with a trading population of more than 5,000. Excellent opportunity for a physician who would be received warmly and eagerly by the citizens in Pennsboro and surrounding area. Contact Mrs. Carolyn A. Tingler, R. N., Pennsboro, W. Va.

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WANTED—General practitioner, between the ages of 40 and 50. Salary dependent on personal qualifications and ranges from $6,995 to $12,210 per year. Write J. F. Heavey, Chief, Personnel Division, VA Hospital, University Drive, Pittsburgh 40, Pa.

WANTED—Physician to serve as chief of outpatient clinic in a 200-bed general medical and surgical hospital affiliated with the WVU School of Medicine. Salary dependent on qualifications. Many fringe benefits. Apply to Hospital Director, VA Hospital, Clarksburg, West Virginia.

WANTED—Physician for general practice. Good opening. Associated with internist and surgeon. Write EKW, West Virginia Medical Journal, Box 1031, Charleston 24, W. Va.

WANTED—General practitioner and internist. Twenty man general practice and specialty group in Taconite area of northern Minnesota. Heavy industrial. New hospital facility completed in 1960. Unusually liberal partnership agreement. Starting salary up to $1200. Excellent hunting, fishing, skiing area. Write A. G. Farley, East Range Clinic, Virginia, Minnesota.

WANTED—House physician for GP duty in general hospital (125 beds). No exchange students. Foreign graduates with immigrant visa and fluent English, $500 monthly and single maintenance. Write Kenneth N. Byrne, M. D., Superintendent, Emergency Hospital, Welch, West Virginia

WANTED—Resident for recently approved three-year training program in Obstetrics and Gynecology. 3,356 admissions per year, of which more than 1,000 are clinic admissions, 3,844 clinic visits in last year and 910 service deliveries. Contact Dr. Irvin S. Perry, Director of Medical Education, Charleston Memorial Hospital, Charleston, W. Va.

MALE PSYCHIATRIST—If you are a male psychiatrist under the age of 50, have your Boards or are Board eligible, you may be interested in directing a privately established out-patient psychiatric clinic in a favorable setting that offers rewarding work and $25,000 per year, net. Write MWH, The West Virginia Medical Journal, Box 1031, Charleston 24, W. Va.

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WANTED—Male psychiatrist under 50 years of age. Board certified or Board eligible to head established private psychiatric clinic in city of 75,000. Graduate of American medical school. Salary: $18,000 to $20,000, depending upon qualifications and experience. Plus liberal fringe benefits. Incentive plan permits additional earnings of $5,000 annually. Write MWH, The West Virginia Medical Journal, Box 1031, Charleston 24, W. Va.

WANTED—General practice resident. Available immediately. $500 per month. Associate with five other general practice residents in 215-bed general hospital. JCAH approved with active teaching program. U. S. citizen or those becoming eligible. Location excellent for future practice. Write to Administrator, Herbert J. Thomas Memorial Hospital, 4605 MacCorkle Avenue, S. W., South Charleston, W. Va.

SITUATION DESIRED — Internist-Physiatrist desires to relocate in the Panhandle area. Interested in associating with progressive individual(s) or group as consulting rheumatologist-physiatrist. Ultimate objective is to help establish and operate an accredited arthritis and rehabilitation center in panhandle. Write FDS, West Virginia Medical Journal, Box 1031, Charleston 24, W. Va.

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JULY
1962

Vol. 58 No. 7

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 343-4607.

Member 1962

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The West Virginia Medical Journal

July, 1962 Vol. 58, No. 7

Carcinoma of the Thyroid*

James E. Boggs, M. D., Robert W. McCoy, M. D., and David B. Gray, M. D.

In the treatment of a patient with thyroid enlargement, one of the most important questions is whether or not an operation is indicated or even justified on the basis of suspected malignancy. The problem arises whether the enlargement be diffuse, with no nodularity, or whether it be a solitary nodule, or multiple nodules.

It has been our impression that the incidence of thyroid carcinoma in this particular area of West Virginia is lower than that reported in the surgical literature for the nation in general. In an effort to confirm our belief, the case records of all patients with thyroid disease, with an established pathologic diagnosis, seen at Charleston Memorial Hospital since its opening eight years ago were reviewed.

Material

During the interval between November 1, 1951 and September 1, 1959, 440 patients either with a primary or a secondary clinical diagnosis of thyroid disease of one type or another were admitted to Memorial Hospital. Of this number, 236 were operated upon and a pathologic diagnosis established.

We limited our investigation to age, sex, symptoms and their duration, operative procedure and pathologic diagnosis. Our goal was to correlate the incidence of thyroid carcinoma in this area of West Virginia with that in other geographic areas of the nation by analysis of the available literature bearing reference to the subject.

Comparative Incidence

In 10 of the 236 surgical cases, the lesion was malignant (Table 1), an incidence of 4.2 per cent for the surgically treated group, which compares favorably with that of 3 per cent and of 3.9 per cent reported in the literature.[1, 2] It likewise represents an incidence of 5.1 per cent for nodular goiter, as compared with 7.2 per cent and 7 per cent elsewhere.[3, 4]

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Submitted to the Publication Committee, January 9, 1962.

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Age and Sex Distribution

The incidence of thyroid disease by decades, with relation to age and sex, may be seen in Table 2. It will be noted that in our series of cases the incidence was highest in the fourth and fifth decades of life. Two hundred twelve patients were female and 24 were male, a ratio of 8 : 1. Of the 10 malignant cases, 8 patients were female and 2 were male, a ratio of 4 : 1. In 5 of the 10 cases, the patient was under 35 years of age. In one published report on thyroid carcinoma, the patient was female in 76 per cent of cases.[5]

Symptoms

Several predominant symptoms were described in the series of 236 cases covered by our study (Table 3). The most common presenting symptom, by far, was a "swelling" or a "lump" in the neck. In 11 cases (4.6 per cent), the patient had undergone thyroidectomy previously, and in 10 of these had been readmitted because of recurrence of the mass. In the 11th case, the patient had been readmitted because of pressure symptoms. In the 10 cases with recurrence, the goiter was nodular while in the 11th case the

patient had Hashimoto's disease. The high recurrence rate of goiter is significant. Many observers believe that recurrence is due to a hormone deficiency, with resultant TSH which, by its continuous stimulation, causes hyperplasia of the remaining thyroid tissue, with subsequent nodule formation. It is felt, therefore, that in many of these cases the patient might derive benefit from prolonged courses of therapy with desiccated thyroid extracted after removal of the thyroid nodules

In 25 cases, a mass was discovered on routine physical examination and, with one exception, all patients were asymptomatic. The one exception was a patient whose only complaint was nervousness. Compared with other reviews on the subject, this represents a low incidence of symptomatic nodules detected on routine physical examination.[6]

As might be expected, duration of symptoms ranged from several weeks, sometimes less, to 40 years or more. In the 25 toxic goiter cases, symptoms had been present for periods varying anywhere from 1 month to 48 months, the average being 13 months. In 20 of these cases, the goiter was diffuse; in 5, it was nodular.

Classification

We classified the goiter in the diffuse or the nodular group (Table 1) in accordance with the clinical impression after physical examination. We included in the diffuse group the thyroiditis cases: struma lymphomatosa, 12 cases; Riedel's struma, 1 case; nonspecific chronic thyroiditis, 1 case; subacute thyroiditis, 1 case. No case of acute thyroiditis was observed in the series. Similarly, no case of malignancy was observed in the toxic group, as compared with the reported incidence of 1.5 per cent and of 0.46 per cent.[7]

The Thyroid Nodules

The matter of thyroid nodules as an indication for surgery continues as one of divided opinion. One group insists that all nodular goiters should be removed, while a second group feels that experience and case selection on the basis of certain criteria should be the governing factors. Exponents of the latter opinion consistently maintain that thyroid cancer is relatively rare and, on this basis, that surgical intervention should be reserved for carefully selected cases alone. The incidence of carcinoma in thyroid nodules removed at surgery varies widely, that is, from 5 per cent to 16 per cent, depending on the care with which cases are selected and on the geographic location, predominantly, of the patient-group.

With regard to the natural history and clinical findings, nodular goiter and thyroid carcinoma have many features in common, so that constant awareness of this fact becomes of consequence in judging whether a thyroid nodule is benign or malignant. Also, it is because of such similarity that so often differentiation is possible only by surgical excision. Many surgeons remove only those nodular goiters showing recent growth and unusual hardness and from which there is evidence of pressure. Such practice serves only to delay excision of the primary tumor, which results in a greater incidence of local and distant metastases.

It is well known that malignancy often is not suspected in certain thyroid nodules until cervical lymph node metastasis has occurred. Existence of a nodule for several years does not rule out carcinoma. Regardless of the criteria for determining preoperatively whether or not a nodular goiter is malignant, the rate of error in preoperative diagnosis is approximately 50 per cent. The surgeon himself, with a nodule in his hand, will be unable to state positively whether or not the lesion is malignant in 40 per cent of these cases.[4, 8]

The authors feel that unless there is a contraindication to the surgical procedure, removal of all thyroid nodules is justified by the high incidence of carcinoma in such nodules. In the majority of reviews, a 10 per cent to 15 per cent incidence of carcinoma in the solitary nodules is reported, and an incidence of 5 per cent in the multinodular cases. Thyroid nodules should not be enucleated. Total removal of the involved lobe, with frozen section examination, is indicated. If both lobes contain nodules, then bilateral subtotal or total thyroidectomy should be performed. In view of the low morbidity and mortality rates associated with surgical treatment of nontoxic nodular goiter, the lesion should receive attention to the same extent as that afforded a breast nodule. If the nodular goiter with carcinoma is allowed to progress to the point at which carcinoma can be diagnosed clinically by the presence of local or distant metastases, the results of treatment are not good. The 80 per cent five-year survival rate drops to 20 per cent.[9]

No thyroidectomy is complete unless both lobes are examined carefully. In addition, there should be careful palpation of the cervical lymph nodes along the internal jugular veins, the recurrent laryngeal nerves and the Delphian node. Firm or enlarged cervical lymph nodes should be removed and examined by frozen section.

There is no question but that all nodules in patients under 30 years of age should be treated

surgically. Nodules of the thyroid in persons of this group have proved malignant in 30 per cent of cases.[4, 10, 11]

In this study, as mentioned previously, the incidence of thyroid carcinoma in those cases which came to surgery was 4.2 per cent, representing 5.1 per cent for combined types of nodular goiter, with 18 per cent for the solitary nodule and 0.69 per cent for the multinodular type (Table 1).

Table 1.—Malignancy Incidence

		Nodular	*Diffuse*	*All*
(a)	No. of cases	196	40	236
	No. malignant	10	0	10
	Per cent	5.1	0	4.2
		Multinodular	*Solitary Nodule*	
(b)	No. of cases	140	56	
	No. malignant	1	9	
	Per cent	0.69	18	

Table 2.—Age and Sex Distribution

Age by Decade		*Male*	*Female*	*Total*	*Per Cent*
1st	xx-10		1	1	0.4
2nd	11-20		15	15	6.3
3rd	21-30	4	25	29	12.3
4th	31-40	6	66	72	30.0
5th	41-50	9	53	62	26.2
6th	51-60	4	38	42	18.0
7th	61-70	1	13	14	6.0
8th	71-xx		2	2	0.8
		24	212	236	100.0

Table 3.—Symptoms

Description	*No. Cases*	*Per Cent*
Mass	153	64.9
Toxicity	16	6.8
Toxicity & mass	6	2.5
Pressure & mass	26	11.0
Nervousness	3	1.3
Nervousness & mass	6	2.5
Soreness	6	2.5
Asymptomatic	20	8.5
	236	100.0

Treatment of Thyroid Carcinoma

The approved surgical method in the treatment of papillary and follicular types of thyroid carcinoma apparently is an issue that cannot be resolved. There are at least three schools of thought: (1) removal of the presenting solitary nodule by lobectomy, with simple enucleation of any palpably enlarged lymph nodes, (2) total lobectomy with excision of the isthmus and unilateral neck dissection and (3) total thyroidectomy with removal of the pyramidal lobe and Delphian nodes and removal of the suprasternal nodes with or without radical neck dissection on the more involved side.

Agreement is more general in regard to undifferentiated carcinoma of the thyroid. Treatment consists of radical excision of the thyroid and radical neck dissection, if possible, followed by x-ray therapy. I^{131} has proved of no value in the primary treatment.[12]

Many observers contend that radical surgery is unnecessary in dealing with the well differentiated papillary and follicular types of carcinoma because of the slow growth rate of these particular lesions and the fact that the patient survives for as long as 10 to 15 years. For papillary carcinoma, they advocate removal of only the lobe involved, together with the isthmus, unless there is extension to the opposite lobe. Moreover, they advocate removal of only the enlarged cervical nodes.[13]

The writers do not feel that slow growth rate of a lesion constitutes adequate grounds for so conservative an approach to treatment in the face of malignant disease for, the fact remains, it is a malignant tumor, it does metastasize, it is a fatal disease. In one series of 180 cases of papillary carcinoma, there was 38 per cent failure in a five-year follow-up period.[14] Ultraconservative treatment of the nature described above is not in accordance with basic concepts of surgical therapy in relation to malignant disease.

Failure to perform *en bloc* dissection of cervical lymph nodes results in a residuum of many pathologic nodes which will carry on the dissemination of cancer cells locally and distantly. One reviewer reported that, "One hundred eighty-two specimens of radical neck dissection for papillary carcinoma were examined and cervical node involvement was found in 84.6 per cent of cases." If there was positive evidence or suspicion of metastasis, the rate of lymph node involvement was 96 per cent, and if the radical neck specimens were clinically negative on examination, positive nodes were found in 61.2 per cent of cases.[15]

From our personal experience, also from review of the surgical literature noting the high (13 per cent, 46 per cent, 54 per cent)[16, 17] incidence of simultaneous involvement of both lobes of the thyroid gland, we believe that wide total thyroidectomy with radical neck dissection on the more involved side should be performed if palpably enlarged cervical nodes are found. This method usually will assure complete removal of the carcinoma within the gland and will increase the uptake of I^{131} by any remaining metastatic carcinoma.

Clinical observations by Crile,[18] also Thomas,[19] support the concept that thyrotropin from the anterior pituitary gland may serve to stimulate or initiate growth of certain types of thyroid cancer. This is more obvious with the papillary (and that with follicular elements) and alveolar adenocarcinoma. Thyroid hormone inhibits the formation of thyrotropic hormone, thereby removing the stimulus to growth of those thyroid cancers dependent on TSH. There are accounts of patients with pulmonary and osseous metastastes treated with desiccated thyroid, with dis-

tinct regression of the lesions and apparent arrest of the disease.[18] There are, however, certain well differentiated thyroid cancers that fail to respond to thyroid hormone.

Case Reports

Case 1. A 67-year-old white female had noticed a solitary mass in the neck for approximately 40 years, with recent enlargement. Right subtotal lobectomy was performed April 6, 1953. The pathologic diagnosis was "alveolar cell adenocarcinoma." No further surgical intervention was attempted. She received deep x-ray therapy (2,200 r) to the area. She expired of her disease March 3, 1955. The case represents a survival of approximately 23 months.

Case 2. An 11-year-old white girl gave a history of a lump in the neck which she had noticed one year previously.

On September 11, 1957, right total lobectomy, excision of the isthmus, and *en bloc* dissection of the enlarged nodes were performed. The pathologic diagnosis was "papillary carcinoma with metastasis to the jugular group of cervical lymph nodes."

Postoperatively, the patient has been taking desiccated thyroid grains 2 daily, and shows no evidence of recurrence 30 months after surgery.

Case 3. A 13-year-old white female had noticed a solitary mass in the neck for the past year; the mass recently had become enlarged, producing tracheal pressure.

The patient underwent total thyroidectomy and radical neck dissection January 30, 1952. She expired the same day. The pathologic diagnosis was "papillary carcinoma with local metastases."

The exact cause of death was not known since permission for autopsy was refused.

Case 4. A 20-year-old white female gave a history of a lump in the neck of approximately 4 years' duration. There were no subjective symptoms.

At operation, May 9, 1957, examination of the lymph nodes by frozen section revealed metastatic papillary adenocarcinoma.

In view of the diagnosis, the operating surgeon felt that radical neck dissection was not indicated. Right total lobectomy was performed, with excision of the isthmus and dissection of the locally enlarged lymph nodes. A portion of the internal jugular vein and of the sternocleidomastoid muscle also were excised because of local invasion. The left lobe of the gland was normal to palpation at the time of surgery.

Postoperatively, the patient was placed on desiccated thyroid extract grains 3 daily. A short time after her surgery she became pregnant. The prenatal course was uncomplicated and she gave birth to a normal infant.

Approximately 15 months after the thyroid surgery, the patient was seen by her surgeon because of a mass in the right side of the neck. She refused to undergo further surgery at that time but consented a few weeks later (September, 1959). A mass 1.5 cm. in diameter was located in the midportion of the right side of the neck.

Right radical neck dissection and left total lobectomy were performed September 14, 1959. Pathologic examination of the specimen showed metastatic follicular adenocarcinoma of the right cervical lymph nodes. There was a noncapsulate sclerosing tumor of the left lobe of the thyroid.

Postoperatively, the patient has been taking thyroid extract grains 3 daily. After seven months, there is no evidence of recurrence.

Case 5. A 45-year-old white female had noticed an asymptomatic mass in the region of the thyroid for approximately five years.

On March 4, 1957, bilateral subtotal thyroidectomy was performed. Grossly, the lesion was considered to be an adenomatous goiter. Microscopic examination disclosed a low grade papillary adenocarcinoma. There were no palpable lymph nodes.

Postoperatively, the treatment consisted of thyroid extract grains 3 daily and, after three years, there is no evidence of recurrence.

Case 6. A 38-year-old white female had undergone total right lobectomy of the thyroid gland in 1940 for nodular goiter. In September 1956, left subtotal lobectomy for benign goiter was carried out. In December, 1957 another mass with progressive enlargement and, ultimately, pressure symptoms, was noted in the left side of the neck.

On August 15, 1958 removal of the remaining thyroid tissue along with modified neck dissection, leaving the internal jugular vein and sternomastoid muscle intact, was performed. The pathologic diagnosis was "low grade papillary adenocarcinoma of the remaining thyroid tissue" and "metastatic papillary adenocarcinoma to the cervical lymph nodes."

Following surgery the patient was placed on thyroid extract grains 3 daily; no evidence of recurrence has been noted 18 months postoperatively.

Case 7. A 25-year-old white female had noticed a mass in the neck for only four months. There had been rapid enlargement of the mass. Thyroid carcinoma was suspected preoperatively because of the palpable cervical lymph nodes on the left.

On October 2, 1958, total thyroidectomy and removal of the left cervical lymph nodes as well as the superior mediastinal nodes were performed. The pathologic diagnosis was "papillary adenocarcinoma with extensive metastases to the left cervical and left superior mediastinal lymph nodes."

The patient was placed on thyroid extract grains 3 daily postoperatively. In May, 1959, approximately eight months later, a mass was noted in the region of the midportion of the neck on the left.

Left radical neck dissection was performed May 8, 1959. Microscopic examination of the specimen showed only a single, large, metastatic lymph node in the midcervical area. The remaining lymph nodes showed nothing more than reticular hyperplasia. The patient was continued on her thyroid extract medication. There is no sign of recurrence after nine months.

Case 8. A 25-year-old white female had been told 18 months prior to her admission to the hospital that she had a thyroid nodule.

On examination, there was an irregular, firm, fixed nodule suggestive of malignancy in the left lobe of the thyroid gland.

Total left lobectomy with excision of the isthmus and a portion of the right lobe was performed March 17, 1959. There was no apparent lymph node enlargement. Frozen section was not done. Microscopic examination disclosed an invasive papillary carcinoma with metastasis to an adjacent lymph node. No further surgery was performed.

Postoperatively, the patient was placed on medication consisting of thyroid extract 3 grains daily. After an eleven-month interval, there is no sign of recurrence of the disease.

Case 9. A 33-year-old white male had noticed a mass in the left posterior triangle of the neck 18 months prior to his admission to the hospital. Biopsy showed metastatic papillary and follicular adenocarcinoma of the thyroid gland. Subsequent to biopsy, on extremely careful palpation of the neck, there was a small, firm, fixed, nodular mass in the left lobe of the thyroid.

Total thyroidectomy and left radical neck dissection were carried out December 16, 1958. The pathologic diagnosis was "fairly well differentiated follicular and papillary carcinoma of the left lobe of the thyroid with metastasis to the left cervical lymph nodes."

Following surgery, the patient was placed on desiccated thyroid extract therapy, to a tolerance dose of 2 grains daily. In the fifteen-month period since his operation, there has been no evidence of recurrent growth.

Case 10. A 78-year-old white male first was admitted to the hospital October 5, 1953, with the history of an enlarged thyroid gland of several years' duration. He had been symptomless until the time of admission, the gland by then having become painful and more swollen. There was a past history of mild diabetes, also of an abscess of the thyroid gland following extraction of a tooth in September 1953.

The patient's second hospital admission was January 24, 1954. During this period an attempt was made to perform thyroidectomy, but because of the friable state of the gland, it was not possible to complete the operation. Biopsy specimens were obtained, however, and on miscroscopic examination the diagnosis was "papillary adenocarcinoma of the thyroid." Therapy consisted of x-ray to the thyroid gland, rendered on an out-patient basis.

The third hospitalization was March 12, 1956 when thyroidectomy was attempted a second time but could not be completed because of extensive bleeding. Again, specimens of the gland were removed which, on biopsy, were read as "low grade papillary adenocarcinoma of the thyroid." At that time the I^{131} uptake was 25 per cent in 24 hours, with an excretion rate of 41 per cent. On March 16th there was no radioactive iodine uptake of the biopsy tissue. The basal metabolic rate March 13th was minus 33. The patient was transferred at this time to the Medical Service Isotope Laboratory.

The fourth hospital admission was August 9, 1956 during which time the basal metabolic rate on two occasions was minus 28 and minus 44, respectively. The cholesterol was 249; there was no I^{131} uptake. An electrocardiogram showed low voltage. The patient was discharged after being placed on thyroid extract grains ¼ daily.

The patient's fifth hospital admission, April 3, 1958, was because of weakness. I^{131} studies at the time showed 0.4 per cent uptake and an excretion rate of 14 per cent which was read as complete myxedema. A chest x-ray was negative for metastasis; there was, however, collapse of T-11 and T-12 from osteoporosis. He was given I^{131} 75 mc.

The sixth hospital admission, in July 1958, was on an emergency basis because of extensive bleeding from the ulceration of the thyroid cancer in the neck. The bleeding was controlled by cauterization. An x-ray at that time showed a 5 cm. mass in the superior mediastinum. He was seen in consultation by one of the writers

(D. B. G.) with regard to the advisability of further surgery because of the progressively enlarging ulcerative tumor of the neck. It was felt that further surgery was not possible without removing the larynx and trachea. Instead, the thyroid extract dose was increased to 6 grains daily, finally being adjusted to 4 grains daily. A second course of x-ray therapy was recommended, and was given.

Within three months after the patient began to receive adequate doses of thyroid extract, the neck had healed; it has remained healed to the present time.

Comment

In a series of 236 cases of thyroid disease, in each of which the treatment was surgical, the occurrence of ten malignant tumors of the thyroid, an incidence of 4.1 per cent, compares favorably with that reported in the literature.[1, 2] The incidence, however, of 18 per cent for solitary nodular goiter and that of 0.69 per cent for multinodular goiter are considerably lower than those noted in reports published by others, e. g., 24.4 per cent, 9.8 per cent; and 24.5 per cent, 3.4 per cent respectively.[20, 2] The malignancy incidence range of 3 per cent to 10 per cent frequently quoted for multinodular goiter probably can be accounted for on the basis of case selection.

The various types of operative procedure used in the cases reported exemplify the rather vast difference of opinion with reference to the surgical management of thyroid carcinoma. In the performance of these operations, the work of four different surgeons was involved, one surgeon operating on three of the patients. In each case the surgical approach differed, ranging from simple unilateral subtotal lobectomy to bilateral total thyroidectomy with lateral neck dissection. The variation in technique lends substance to the thought expressed by Frazell and Foote,[15] which is, that the proper therapeutic approach is difficult to determine in dealing with papillary carcinoma of the thyroid. One point on which there is complete agreement, however, if we may judge from the surgical literature, is the axiom that the malignancy must be excised together with a surrounding zone of normal thyroid tissue and that in no circumstances should the tumor itself nor any of the metastatic nodes be incised. Crile[21] demonstrated that the incidence of distant metastases was nearly ten times higher in cases in which the tumor was incised at the first operation.

To cloud the issue further, particularly with regard to management of carcinoma in the younger age group, Lahey[22] states that thyroid cancer in persons of younger age tends to be of less malignant pathologic types and less advanced in growth. Horn[23] states that malignancy in older patients is of high grade while that in younger patients is of low grade. In contrast, another study recently has been published in which the author[24] states that from his study it appears that lesions in young patients are as malignant as those in patients past the age of forty. Since completing our review of cases, we are inclined to agree with this observer even though the follow-up period in our cases is short.

It becomes readily apparent, then, that in dealing with papillary carcinoma of the thyroid, a uniform method of surgical treatment has not been established. Especially is this noticeable in a 300 bed general hospital with a surgical staff composed of members trained in different large institutions and who, quite naturally, reflect the teaching of their various residencies and other postgraduate training in the approach to surgical problems including that of thyroid carcinoma. Of the latter it might be said that the only form of treatment in common use at the present time is the postoperative therapy consisting of ingestion of thyroid extract to a tolerance dose of 2 to 4 grains daily, as advocated by Crile.

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'New Products Parade'

Even as in ancient Egypt, and elsewhere, fat periods are succeeded by lean ones, and so it may be in the pharmaceutical industry. Paul de Haen, consultant to this and allied forms of human endeavor, has indicated in his annual "New Products Parade"—a painstaking analysis of the business—that 1961 may be classified as a lean year in the introduction of new therapeutic agents. Leanness, however, need not be considered a sign of ill-health; excess fat, according to most authorities, is more to be avoided.

Mr. de Haen goes on to compare 1961, or any recent year, with 1934, only twenty-seven years ago. It was the year before the sulfonamides appeared—a year when the really effective drugs could practically be counted on the human digits—a year that might be considered as ending the old era of drug therapy and marking the beginning of the new. It has been a new era not only of effective treatment, however, but of risky side effects; of iatrogenic hazards.

Sales, nevertheless, have apparently continued to increase in 1961, even with fewer new products to market. Advertising, at least in many of the medical journals, has fallen off, perhaps because less promotion of products that had presumably become established has been considered necessary; perhaps because of the recession in other businesses; perhaps because the Kefauver inquiry had occasioned some confusion in the industry over the invulnerability of its methods of distribution and promotion.

The figures reported by Mr. de Haen indicate that in 1961, 111 leading firms produced a total of 265 new items, compared with 311 produced in 1960 and 315 in 1959. The banner year of the past decade in this respect was 1955, with 403 products emanating from 126 firms. In 1961 only 41 new single chemicals were introduced—which one might think would be enough—as compared with 45 in 1960 and 63 in 1959, the peak year in this department. The hard-pressed physician might agree that a relative moratorium in which to catch his breath would be salutary.

Ataraxics continue to intrigue those whose concern is with emotional tension, which seems to be nearly everyone, and these agents are being introduced into the human frame in such subtle forms as "suppositories, emulsions, long-acting tablets and parenterals." In the face of this great variety of antitensive agents 3 new compounds have been elaborated to elevate the mood of those whose mood needs elevation.

To preserve or rectify the integrity of the integument no less than 33 new formulas and 11 new dosage forms of older products have been devised for external application. New hormones, many new medicines to put the gastrointestinal tract in order and, perhaps with considerable justification, new products for the relief of fatigue are being marketed.

A disturbing factor is an increasing tendency on the part of some manufacturers to rely on the often valueless "personal communication" or the unpublished paper, in an attempt to seem to document the value of a product.—New England Journal of Medicine.

Pulmonary Actinomycosis Resembling Bronchogenic Carcinoma

George E. Farrell, M. D., and Philip W. Oden, M. D.

PULMONARY actinomycosis occurs in only 15 per cent of cases of infection by Actinomyces bovis.[1] The disease has been subdivided into two types. In the first, the primary involvement is in the hilum, with the lesions extending into the lung along the bronchi, causing considerable fibrosis. In the second type, the primary involvement is in the parenchyma with or without abscess formation. It later may extend to the pleura and the ribs. Bone involvement is typical of the disease.[2]

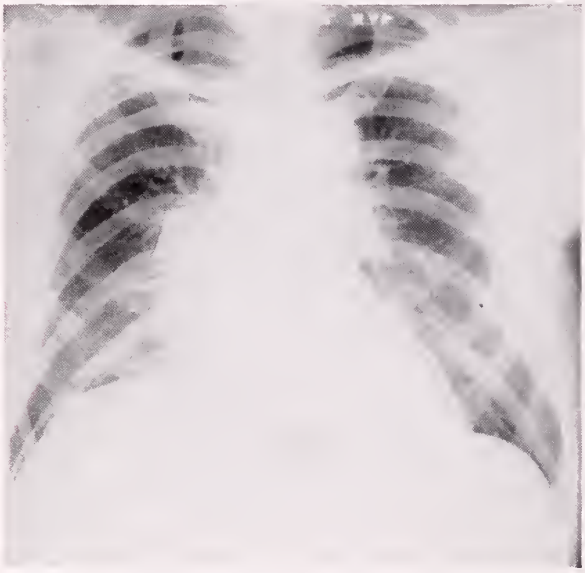

Figure 1. The right hilum is markedly enlarged. The right diaphragm is elevated. The heart and mediastinum are slightly deviated to the right. This may be due to atelectasis. Conclusion: Probable bronchogenic carcinoma.

An example of the first type follows.

Case Report

A 50-year-old white male was admitted to the Greenbrier Valley Hospital on December 10, 1956, with a history of cough, weight loss, right sided wheezes and chest pain. The pain was severe and was relieved by medication. The weight loss was recent. The patient stated that he was a very heavy cigarette smoker.

Physical examination revealed right sided wheezes and diminished breath sounds in the right posterior lung field. There also was evidence of recent moderate weight loss.

Submitted to the Publication Committee, November 1, 1961.

The Authors

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Laboratory.—Urine, bleeding time, clotting time, prothrombin time and glucose tolerance test were reported as within normal limits. Blood serology was negative. The blood count, except for 11,600 WBC, was normal.

X-Ray.—"The entire right hilum is markedly enlarged. The trachea and mediastinum are deviated to the right. The right diaphragm is elevated. Conclusion: Mass involving the right hilum with atelectasis of the right lung which is probably bronchogenic carcinoma."

The patient was referred to another hospital for bronchoscopy which was followed by right pneumonectomy.

Thoracotomy revealed a large mass involving the hilum of the right lung, extending to the anterior chest wall, pericardium, mediastinum, almost to the level of the diaphragm. The mass was hard, with an ulcer which was somewhat boggy in consistency. More extensive pleural adhesions about the lower half of the right lung required extrapleural dissection in this area.

Pathologic Diagnosis.—Actinomycosis.

Discussion

A case of pulmonary actinomycosis closely resembling bronchogenic carcinoma is reported. In such instances it is difficult to know just how the diagnosis can be made from x-ray and clinical studies alone. If a productive cough is present, smears and cultures will demonstrate the organism in the sputum. Such studies should be made routinely in these cases.[1]

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Newer Diagnostic Office Procedures*

John H. Hodges, M. D.

The appraisal of new diagnostic procedures is destined to include a revival of older procedures, a re-emphasis of the importance of certain procedures and modern variations of valuable methods of studying a patient.

Clinical medicine has a history dating back to Hippocrates whose descriptions of disease were written five centuries before Christ. The practice of medicine in the following 2200 years was characterized principally by diagnosis derived from an evaluation of the variations of the patient's symptoms. Physical diagnosis was limited to visual perception, usually an appraisal of the patient's general appearance plus careful evaluation of his pulse. Long overdue advances in physical diagnosis were made with the description of percussion by Auenbrugger[1] in the 18th century and with Laennec's[2] 19th century account of auscultation by use of the stethoscope.

The Stethoscope

Our present day binaural stethoscope is a much more comfortable instrument than the short, rigid tube used by Laennec; one wonders, however, if it is not probable that he heard more than we are hearing when we use stethoscopes with long, large bored tubing. Accurate studies[3,4] show that the shorter the tubing the better the sound. A ten to twelve inch length is the most practical. The sound wave lengths in auscultation of the heart and lungs are ideally conducted by tubing with ⅛ inch bore. An instrument with interchangeable diaphragm and bell is ideal. The diaphragm should be 1½ inches in diameter and the bell should be relatively shallow.

The Ophthalmoscope

The ophthalmoscope is not a new instrument, but frequently it is thought of as one to be used only by the ophthalmologist. An ophthalmoscopic study is easily integrated into the routine examination. A short period of practice can restore confidence in its use. There is no need, in most instances, to put drops in the patient's eyes nor to wait for accommodation. Simply darken the room and in one minute's time it will be possible to detect, if present, early lens opacities, retinal hemorrhages which may be the first objective incidence of a blood dyscrasia or the first warning of the change in hypertension from a benign to a malignant type. Choked disc may be observed, or optic pallor, arteriosclerotic and hypertensive arteriolar change, enlarged vessels in primary or secondary polycythemia and various other abnormalities. The examiner may not always arrive at the exact diagnosis of the retinal lesion, but at least he will recognize the need of referring the patient to an ophthalmologist.

The Author

- **John H. Hodges, M. D., Associate Professor of Medicine, Jefferson Medical College, Philadelphia, Pa.**

Secretions, Excretions and Albuminuria

The general appearance of the secretions and excretions has long been an important part of the description of disease. It was not until 1695, however, that Dekkers[5] demonstrated the presence of albumin in the urine by means of heat and acetic acid. The first recorded blood count was in 1852 by Vierordt,[6] who found that his own blood contained 5,010,000 erythrocytes per cu. mm. The science of morphologic hematology had its inception in 1878 with Erlich's[7] invention of the first practical blood stain.

Physical Diagnosis via Laboratory

This relatively young science of laboratory medicine, this extension of physical diagnosis into the fields of chemistry, biology and physics, has become a requisite in the practice of medicine. It is commonplace for the physician to have the equipment for urinalysis, blood count, simple blood chemical procedures and bacteriological staining. He usually has ready access to procedures which require spectrophotometers, bacterial cultures, flame photometers, electrophoretic devices, ultracentrifuges, and even cold centrifuges, also Geiger counters, well chambers and other accouterments of the atomic age.

The requirements of training, finance and time are forcing the aggregation of this highly specialized equipment into centers, such as hospitals and endowed laboratories, where their use may be shared by many.

*Presented before the Sixth Annual Potomac-Shenandoah Valley Postgraduate Institute at Martinsburg, October 27, 1961.

Submitted to the Publication Committee, February 2, 1962.

Simple tests may be performed by the physician or his office assistant. The physician still retains the direction of the choice of the more involved procedures which would aid in the diagnosis and the evaluation of the patient's progress and the prognosis of the disease. He should have knowledge of the types of specimens required by the laboratory for specific tests.

In the time allotted we shall attempt to indicate some of the newer tests, to emphasize the value of some which are not so new and to point out some of the indications for the more complicated procedures which require the use of specialized laboratories. It is appropriate from the historical standpoint to start with urinalysis.

Analysis of Urine

It is important to emphasize the fact that negative chemical tests on urine are not valid if the specific gravity is below 1.007. The heat and acetic acid test and the sulfosalicylic acid test have equal merit for the determination of proteinuria. The sulfosalicylic acid test is simpler to perform and less time consuming. The test for glucose has been made specific with the use of the enzyme glucose oxidase, which has been conveniently arranged in commercially available products. These products have the disadvantages of possible deterioration, difficulty in obtaining a quantitative result and overspecificity in that they do not detect other reducing substances in the urine; they are extremely simple, however, for the known diabetic to use. Benedict's reagent still is the best material to use as a screening test for reducing substances in the urine. Acetest* is a good reliable tablet for detecting the presence of acetone bodies in the urine. The Ictotest* is a sensitive test for bilirubin; the capriciousness, however, of the various bilirubin compounds in this chemically variable substance, urine, makes it necessary to check with other tests, such as Harrison's, if the Ictotest is negative or indecisive. Urinalysis in infants should include routinely the use of 10 per cent ferric chloride solution to detect phenylpyruvic acid, particularly in view of recent knowledge that phenylalanine deficient diets may be effective in preventing the permanent mental deficiency which is a certainty if this hereditary illness goes undetected through the first year of life. Phenistix* reagent strips seem to have a good degree of accuracy for detecting phenylketonuria; in addition, they will turn pink on contact with urine of patients taking salicylates or phenothiazine derivatives and therefore may be used to check on the drug usage of the patient.

Sjoerdsma[8] and his group have described a simple procedure for detecting 5-hydroxyindolacetic acid in the urine. A positive test is presumptive evidence of metastatic carcinoid or argentaffinoma.

Hormones in urine such as gonadotropins for pituitary function, estrogens for ovarian function and corticoids for adrenal function can be determined quantitatively by a good endocrine laboratory from a refrigerated 24 hour urine specimen. A simple screening test for adrenal cortical insufficiency is the water loading test: The patient drinks water 20 ml./kg. of body weight over a half hour period. If the total volume of urine over the following four hours is less than 50 per cent of the volume of water consumed, the test is positive.

A specific gravity of over 1.020 in a random urine specimen, which is negative for reducing substances and protein, is presumptive evidence of normal kidney function. Intravenous pyelography will temporarily raise the specific gravity of the urine and invalidates the test for about 24 hours.

The intravenous phenolsulfonthalein test performed in 15 or 30 minutes still is the simplest, the safest, and the most practical office test of renal function.

The appearance of organisms in an unstained wet sediment from fresh clean-voided urine specimens[9] is presumptive evidence of urinary tract infection.[10] The presence of increased numbers of leukocytes is additional evidence. Blue staining cells with granules in brownian movement with the Sternheimer-Malbin stain[11] or the presence of leukocyte casts is significant evidence for the diagnosis of pyelonephritis. The number of colonies/ml. of urine in a urine culture is the final deciding point between the presence of a true urinary tract infection and incidental contaminants. The minimal number lies between 30,000 and 100,000 organisms/ml. of urine and varies with the laboratory in which it is performed.

Blood Constituents Determinations

The present knowledge of the ease of transmission of serum hepatitis by contaminated needles and lancets makes imperative the use of disposable lancets for obtaining blood specimens by skin puncture.

The stained blood film remains the most useful tool for appraisal of the morphology of blood. Cover slip preparations are an improvement over the ordinary blood films on glass slides because they allow a more even disbursement of cells and cause less morphologic distortion. Blood films can be obtained with a high degree of excellence if

*Ames Chemical Co.

the slides and cover slips are prepared by cleansing with 95 per cent ethyl alcohol.

The acid hematin and oxyhemoglobin methods of determining hemoglobin gradually are being replaced by the cyanmethemoglobin procedure.[12] The compound formed in the cyanmethemoglobin procedure is more stable and can be standardized by standards recommended by the American Society of Clinical Pathologists. Cyanmethemoglobin measures total hemoglobin. The other procedures do not measure methemoglobin and carboxyhemoglobin. The Haden-Hausser apparatus, utilizing the acid-hematin method, remains the simplest, cheapest, most practical and accurate direct vision outfit for the determination of hemoglobin.

The serum iron determination requires only a specimen of clotted blood.[13] The normal values range from 80-180 micrograms/100 ml. Iron must be transported in the serum by a special protein, transferrin, and the amount of iron which can be transported depends upon the quantity of transferrin in the serum. The quantitative determination of the carrying capacity is known as the iron-binding capacity and averages 350 micrograms. The simultaneous determining of the serum iron and the iron-binding capacity permits certain diagnostic inferences, as follows:

1. Simple chronic anemia such as in malignancy, infection and uremia is characterized by a low serum iron and low binding capacity.

2. Iron deficiency anemias are characterized by a low serum iron and a normal or elevated binding capacity.

3. Hemolytic anemias are characterized by a normal or elevated serum iron. The iron binding protein frequently is saturated.

The determining of the serum iron may be an aid in differentiating infectious hepatitis from obstructive jaundice because the serum iron is almost constantly elevated in infectious hepatitis.

Bleeding Diseases Tests

Bleeding diseases usually are suspected from the patient's history or by the presence of purpura. Office laboratory procedures for determining the specific defect are the blood count, platelet count, coagulation time and clot retraction, tourniquet test and skin bleeding time with raised venous pressure. Four and one-half ml. of venous blood can be placed in a tube containing one-half ml. of tenth molar sodium oxalate to be sent to a laboratory for prothrombin time determination. The silicone coagulation time is particularly useful in detecting coagulation defects.[15] The Lee and White coagulation test is helpful and, although less sensitive, it remains the most practical test for following patients who are receiving heparin therapy. The capillary glass tube coagulation time should not be used because of its lack of sensitivity. The method utilizing plastic capillary tubing seems to be preferable.[16]

The ease of differentiating the various types of hemoglobin by electrophoresis has made recognition of the expanding members of the group of hemoglobin diseases relatively simple.[17] The procedure requires only a few ml. of blood to which an anticoagulant has been added. Electrophoresis of serum proteins gradually is evolving common patterns of disease.[18] Special staining of these strips reveals the lipoprotein curves. It appears as though a variation in the quantity of alpha and beta lipoproteins may indicate a method of differentiation between hepatocellular and obstructive jaundice. Serum cholesterol evaluation and the determining of other lipids have a distinct value in the prognosis of atherosclerosis;[19] a cloudy fasting serum, however, may indicate hyperlipemia even though a cholesterol determination may be normal. Cholesterol determinations in the postoperative state, at the time of acute myocardial infarction and during an infection, are likely to be lower than those during relatively normal periods and, hence, may give a false sense of security. Also, it is a biological phenomenon for the cholesterol value to fluctuate up and down over a week or ten days so that a true level requires an average of serial determinations performed at weekly intervals. The specimen should be clotted blood collected in the fasting state.

Diagnostic Use of Enzymes

The newer literature contains many articles about the diagnostic use of enzymes in clinical medicine. The findings frequently are controversial or inconclusive. A summary of the pertinent findings can be made in a few statements: The serum glutamic pyruvic transaminase (SGPT) has little more significance than the serum glutamic oxalacetic transaminase (SGOT) except that it tends to reach even higher levels in infectious hepatitis. Serum lactic dehydrogenase (SLD) is more consistently elevated in myocardial infarction than is the transaminase and the elevation persists for a longer period of time. The serum lactic dehydrogenase usually is elevated in pulmonary infarction while the transaminase remains normal.[20]

Bone marrow aspiration can be a practical office procedure. If the physician is not familiar with bone marrow morphology, he can send simple marrow films, stained and unstained, to a competent hematologist for interpretation.

The performance of various laboratory tests in the collagen diseases is revealing some overlap or transition between such syndromes as systemic lupus erythematosis, scleroderma, dermatomyositis, polyarteritis nodosa and rheumatoid arthritis. In fact, the frequency of these diseases in blood relatives suggests a common genetic factor. The L. E. cell phenomenon seems to be most frequently positive and productive of more positive cells in lupus, but is not exclusive for this disease.[21] Three ml. of heparinized blood are needed for the test and it can be performed in the office laboratory if a pipet shaker and means of incubation at 37 C. are available. One of the simplest tests for rheumatoid arthritis is the Latex Fixation test. Simple, commercially available kits require only a drop of the patient's serum. A negative test usually excludes active rheumatoid arthritis.

Blood Glucose

Blood glucose determinations have been made more specific for glucose by substituting either the Benedict or the Somogyi-Nelson procedure for the Folin-Wu method. The newer values for fasting blood glucose are 60-100 mg./ml.; nonfasting levels should not be over 150 mg. Blood glucose determinations made two hours after a high carbohydrate meal, in preference to fasting specimens, will enhance the detection of diabetes mellitus by approximately 25 per cent. Five ml. of blood collected in a tube containing oxalate as an anticoagulant with fluoride as a preservative can be used to determine the blood glucose as long as 24 hours after collection.

Gastric analysis has for its prime purpose the determining of the presence or absence of free hydrochloric acid. The process of swallowing the tube is energetically objected to by many patients. The Tubeless Gastric Analysis, the Diagnex Test Kit supplied by E. R. Squibb & Sons, is a simple and reliable substitute test if used in conjunction with histamine as a stimulant. Its only disadvantage is that some values fall in the intermediate zone, between the presence and absence of free hydrochloric acid. The test requires no special equipment and can be performed readily in the office.

Radioactive Tracer Substances

Radioactive tracer substances have been a considerable aid in diagnosis. Radioactive chromium-51 tagged red cells are used to determine the life span of the red cell in hemolytic anemias; radioactive B-12 absorption and excretion (the Schilling test) is used as the final deciding evidence of the presence of pernicious anemia if the malabsorption syndrome or other causes of impaired gastrointestinal absorption can be excluded. The absorption of I-131 labeled triolein and oleic acid aid in differentiating pancreatic disease and sprue.

The excretion of chloride ions in sweat in values over 60 mEq./liter are diagnostic of cystic fibrosis in children. In adults values over 100 mEq./liter are significant.

A battery of tests for thyroid diseases has evolved. The newer ones are based upon the determination of iodine or radioactive iodide. These iodine estimations are based on the fact that the thyroid hormone, its precursors and metabolites are the only iodine-containing substances synthesized in the body. In a subject who is in iodine balance the inorganic iodide accumulated by the thyroid each day is equal to the amount of organic iodide excreted.

CHART 1: THYROID FUNCTION TESTS

	Normal	*Hypo-*	*Hyper-*
Radioactive Iodine Uptake	20-50%	less than 20%	above 50%
Protein-bound Iodine	3.5-8 ug	0-3.5	8 plus
Conversion Ratio	10-40%	below 10%	above 40%
Erythrocyte Uptake	11-18%	below 11%	above 18%
Butanol Extractable Iodine	(0.3 - 0.8 ug LOWER THAN PBI)		

Thyrotrophic Response Test — Basal Metabolic Rate
Serum Cholesterol

The radioactive iodine uptake requires the swallowing of a tracer dose by the patient and his return in 24 hours for estimation by Geiger counter.

The protein-bound iodine requires a blood specimen.

The conversion ratio is the ratio of the total blood I-131 to the protein-bound I-131 after a dose of 50 microcuries of I-131.

The erythrocyte uptake requires only 3 ml. of blood containing an anticoagulant. It can be used in the presence of iodine contamination.[22]

The butanol extractable iodine is a technical alteration of the P. B. I. which eliminates nonphysiologic iodides in the blood in thyroiditis or in malignancy of the thyroid gland.

Other tests are the thyrotrophic response test, basal metabolic rate and serum cholesterol.

CHART 2: PROTEIN-BOUND IODINE (PBI)

Normal	3.5 - 8 ug	Pregnancy	up to 10 ug
Hypothyroidism	0 - 3.5 ug	Hyperthyroidism	over 8 ug
		Nephrotic Syndrome	depression
		Malnutrition	depression
		Triiodothyronine	depression

(Calculated Error: 0.5 - 1 ug)
Triiodothyronine such as Cytomel depresses the P. B. I.

CHART 3: INVALIDATION OF PBI

	Postpone Test
1. Single Ingestion of Iodides	4 Days
2. Long Term Ingestion of Iodides	2 Months
3. Lipid-Soluble Iodinated Contrast Media (Telepaque; Lipiodol)	2 Years
4. Mercurial Diuretics	4 Days
5. Water-soluble Contrast Medium (Diodrast)	4 Weeks (plus)

This chart shows the necessary waiting period after various contaminations with iodine before the P. B. I. once again is a valid laboratory test.

Summary

The development of improved methods of examination and the formulation of more concise laboratory procedures contribute to the ideal of better patient care and to greater satisfaction for the physician in the practice of medicine.

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℞, ALTA

The interest of the Government of Alberta in pharmacy, pharmacology, generic names, drug prices and other aspects of medication has been evident for some time. This interest has found expression in a recent amendment to the Alberta Pharmaceutical Association Act which permits pharmacists to substitute the generic equivalents of drugs prescribed by a doctor. The operative portion of the legislation is phrased as follows:

"45. Where a prescription refers to a drug or drug combination by a brand name or a name other than its generic name, a pharmaceutical chemist, in dispensing the prescription, may use a drug or drug combination that is the generic equivalent of that named in the prescription unless the prescriber indicates otherwise, (a) by designating the name of the manufacturer, or (b) by specifying that no equivalent is to be dispensed."

The amendment raises several interesting questions. Does it infringe on the age-old assumption of prescribers that their order "Take thou" expressed in the second person singular, imperative mood, of the Latin word *Recipe* is a literal instruction to dispense the medicine ordered and nothing else?

Are the generically named drugs of an unknown manufacturer actually the pharmaceutical equivalents of named preparations? Are the patient's and the doctor's interests adequately protected by the discretionary powers conferred on the pharmacist? Is the patient likely to be provided with drugs at lower cost? Will the doctors make extensive use of the no-substitution clause? Will pharmacists assume the responsibility in substituting equivalents?

At present no authoritative answers are available, but all concerned will observe the developments in Alberta with a great deal of interest.—Journal of the Canadian Medical Association.

Special Article

Life of Dr. John Walter Ramsey*

Clinton F. Israel

JOHN WALTER RAMSEY was born May 16, 1832, at New Geneva, Fayette County, Pennsylvania. New Geneva is situated in close proximity to the Mason-Dixon line, not far from Uniontown and the West Virginia border.

Following a few years of elementary schooling in the community of New Geneva, Ramsey entered Monongalia Academy at Morgantown. After his graduation from the Academy, he enrolled at Jefferson Medical College in Philadelphia from which he graduated in 1853 at the ripe old age of 21, with a diploma to practice medicine and perform surgery in the locality of his choice.

Jefferson Medical College was one of the few outstanding medical colleges in this country at the time and its graduates thus enjoyed a high degree of prestige. A young doctor setting up an office, nevertheless, experienced a difficult time until he had proven himself and had gained a reputation and the confidence of the community in which he had chosen to practice.

To convey some idea of the problems facing a young doctor of that era, permit me to quote from an advertisement in a news medium of the day. A certain community advertised its need of a physician and set forth his necessary qualifications as follows: "A full knowledge of medicine, honesty, sobriety, well married and must look like a doctor." You can well imagine Doctor Ramsey's situation following his graduation from medical college. He was but 21, lacked a wife, a beard, a tall silk hat and a Prince Albert coat, all of which were necessary accouterments not only of professional men but of businessmen as well. About the only prerequisite this young man possessed at that moment was his knowledge of medicine along with a smattering of surgery.

After graduating from medical college, Doctor Ramsey returned to the place of his birth and began the practice of medicine. Little is known of his life during the next five years except that in 1858, on a day in May, he married a young woman by the name of Virginia Hoffman, of Morgantown, whom he had met while a student at Monongalia Academy. To this union were born four children—Luey, Evans, Robert and Raphael, all now deceased.

The Author

- **Clinton F. Israel, President, Master Glass Company, Clarksburg, W. Va., and a Past President of the Clarksburg Chamber of Commerce.**

Military Record and Experience

At the outbreak of the war, in 1861, Doctor Ramsey joined the Confederate Army and the record shows that his advancement in rank was rapid. His first rank was Regimental Surgeon. From that he was promoted to Chief Surgeon of his Division and then to Medical Director of the Division. He participated in all major battles of the Shenandoah Valley. The medical profession at that time knew almost nothing of sepsis, sterilization or infection. It was believed that a wound was not healing unless quantities of pus were expressed. There were no hospitals to speak of, very few women nurses, no screens on windows or doors, and flies by the millions. After a major battle, war surgeons literally stood in blood for hours while working. Amputated limbs accumulated so fast that they were stacked like cord wood until their final disposition. His war time experience and training made of Doctor Ramsey a fearless surgeon as well as an outstanding member of his profession.

A Prisoner-of-War's Decision

Toward the close of the war, John Walter Ramsey was captured by the Union Army and taken prisoner. Doctors were scarce and the war had intensified the scarcity. Professional men of Doctor Ramsey's caliber were not destined to lead the life of a prisoner-of-war but, rather, were paroled to some community in dire need of a doctor. Thus, Ramsey was paroled to Clarksburg and, liking the town and its people, decided

*Presented before a meeting of the Clarksburg Chapter of the United Daughters of the Confederacy on January 22, 1962.

Submitted to the Publication Committee, February 21, 1962.

at war's end to remain there. He rented and later purchased a small dwelling at the corner of Main and Water streets, setting aside one of its rooms for his office. Nearby he provided a stable for his horses. In those years a doctor was judged not only by his professional skill but also by the quality of his horses.

Steeds and Stables

John Ramsey was a genuine horse lover and fancier. His stables were filled with the best horses obtainable in thoroughbred stock. He conceived the idea that a horse's hooves should be soaked in water regularly, and employed Dr. Cecil B. Jarvis, as a boy who lived with his parents close to Elk Creek, to lead his horses up and down the creek for certain periods each day. Nowadays this treatment would be termed "hydrotherapy." The doctor favored black horses and these he supplied with harness painted white, using common house paint. Here was a sight to behold as he drove over the streets of Clarksburg and vicinity.

One of the doctor's steeds had a scraggy tail which did not do the horse justice. He had the tail shaved, and constructed a false tail, or toupee, from horsehair and attached it to a leather sheath which he then slipped over the shaven tail. The false tail was held in place by a specially designed crupper strap. I am informed that after installation of this wig on the reverse end, both horse and doctor were more than pleased with the arrangement.

Old-timers who remember him well have said that the doctor and his horses were at their best during sleighing season. A team of thoroughbred black horses with white harness along with the best set of Swiss sleigh bells that money could buy would cause anyone to pause and admire.

Merited Honors and Max Riddle

Doctor Ramsey was an intellectual as well as a capable physician. Regardless of common practice or custom, he set his own standards and from them never deviated. He enjoyed an enormous practice over the central area of West Virginia. An ethical practitioner, honors came to him fast. He was elected president of the newly formed Harrison County Medical Society, president of the State Medical Association, was appointed surgeon for the Baltimore and Ohio Railroad and was a member of the Board of Directors of the state mental institution at Weston.

While serving on the Board of the Weston Hospital, Doctor Ramsey became well acquainted with the late Dr. T. M. Hood who was in charge of the hospital at that time. When Doctor Hood moved to Clarksburg in 1897, he brought with him a colored boy whose duty was to care for his horses and cow. The boy, associating with members of his own race in the big city, soon became trifling and was discharged by Doctor Hood as worthless. The boy later was employed by Doctor Ramsey to care for his horses and as a driver. One day Doctor Ramsey on meeting Doctor Hood on the street said, "Doctor Hood, that is the handiest boy I ever had. When suturing a wound he always knows which needle to take from the back of his coat lapel and hands it to me already threaded." The boy's name was Max Riddle and returning to Weston he lived to a ripe old age.

Scion Robert Ramsey, M. D.

Doctor Ramsey's son, Robert, graduated from West Virginia University and was a classmate of Captain Kemble White. Robert was a handsome man and, like Captain White, was commissioned Captain and served in the Medical Corps of the United States Army during the Spanish American War. He then entered Jefferson Medical College and graduated in three years, following which he joined his father in the practice of medicine. Shortly afterward an epidemic of smallpox broke out in the Lost Creek vicinity. Dr. John Ramsey, realizing the seriousness of the situation, sent Robert to care for the stricken. Robert stayed in Lost Creek almost three months, until the epidemic had subsided. He himself contracted the dread disease and was left pockmarked to some degree.

The father and son established an office over what was known then as Criss's Drug Store, located at the corner of Pike and Third Streets on the exact site of the present Latstetter Building. Robert Ramsey met a tragic death while still a young man. He fell from an open window of their second-story office, striking a rain barrel and breaking his neck.

'Fine Figure of a Man'

Regardless of the sad loss of his son and despite his advancing years, Doctor Ramsey waged war against old age until his last breath. Those who knew him well described him in this fashion:

"A fine figure of a man, with military posture, always straight-backed. He wore a flat-topped derby hat, a luxuriant black beard, along with a wing collar and an elegant tie; a fancy vest with a gold watch chain, a cutaway coat and detachable cuffs with cameo cuff links. On the street he carried a gold-headed cane that never touched the ground. His shoes were remarkable—he

painted them various colors. It has been said that when invited to a social function he always made sure of the color combination of his lady's apparel so that his shoes would not clash color-wise. He had as many as twenty pairs, painted in all colors and shades of the spectrum."

As old age caught up with him, the doctor fought it vigorously. He never admitted failing eyesight and refused to sanction eyeglasses. He would stride manfully down street with his cane at a jaunty angle, ofttimes running into people or over them, all of which would anger him because of their getting in his way. Frequently he would stumble, after which he would take several quick steps as if to catch up. As streaks of gray showed in his beard he used black shoe polish to keep it black. The polish sometimes would wander to the bosom of his white shirt. This was not due to his becoming slovenly but, rather, to failing eyesight.

This great personality and outstanding disciple of Aesculapius finally surrendered to his bitterest enemy, "Old Age," and died February 3, 1909, at the age of 77 years. He and his son, Robert, are buried in our own Odd Fellows Cemetery. His wife and other children are buried in Morgantown.

Quo Vadis?

There is a legend that St. Peter, the head of the new Church which Christ had founded, was leaving Rome when he met an apparition of the Lord on the Appian Way. The apparition of Christ said to Peter: "Quo Vadis?" Where are you going? The story goes on that Peter who was running away from his responsibilities, turned back to Rome and stayed on to lead his people until he was martyred.

Without meaning any disrespect, we wish to draw a simile. We wish that the spirit of George Washington could appear to the American people, or at least to their leaders, as they race along Highway 66, and ask them if they know where they are going. Thoughtful citizens have been disturbed by the trend in this country toward the welfare state. Not only are millions of individual Americans accepting financial handouts from the Federal and state governments, but state and municipal leaders are constantly looking to Washington for funds for local projects. No longer do our political leaders believe as Thomas Jefferson did, that the best governed people are the least governed. Rather, the idea seems to be that only the social planners in Washington are wise enough to direct our lives and even to run our business affairs. Citizens are not considered smart enough to protect themselves with health insurance, so government will compel them to have such protection under Social Security.

What is so disturbing about this trend to let the Federal government run our lives is that so few seem to realize how our individual freedom is being eroded. The indifference of the people to the ultimate effect the welfare state will have upon our precious heritage of liberty is frightening. The danger is that some President will decide to rule by fiat and assume the powers of a dictator. It has and is happening elsewhere.

We are most disturbed to hear physicians say they do not want to get mixed up in politics. They argue that as physicians they must give undivided attention to the care of the sick, hence, have no time to write congressmen, get out the vote for favored candidates—or even go to the polls themselves. Anathema on such physicians! We are all citizens first and physicians secondarily. Physicians can, and have been, patriots. Four signed the Declaration of Independence. Exiled Cuban physicians now wish they had taken an active part in politics before Castro took over. Their intelligent leadership might have prevented Cuba from going Communist.

Quo Vadis? That is up to each citizen to decide. Let us hope that enough Americans care enough for the U.S.A. to actively oppose the trend to the Welfare State.—John G. Slevin, M. D., in Detroit Medical News.

95TH ANNUAL MEETING

of the

West Virginia State Medical Association

The New West Virginia Wing

The Greenbrier

AUGUST 23-25, 1962

Plan to Attend — Make Your Reservation . . . Now !

The President's Page

The Voluntary Approach

SINCE the end of World War II there has developed a phenomenal increase in voluntary health insurance in the United States. At the present time there are an estimated 132 million people, or well over 70 per cent of those eligible for enrollment, with some type of prepaid medical insurance. There has not only been a numerical increase in subscribers but in addition an ever widening scope of benefits have become available. As physicians we have initiated some plans, advocated and sponsored others as a method of financing medical care for our population. The Blue Plans were initially sponsored by the medical profession to help the low income group finance their medical care. These plans have since expanded to embrace all economic segments of the population. At present there are 82 Blue Shield and 78 Blue Cross plans in operation with a total membership of 49,122,164 as of December 31, 1961.

When one considers the relatively few years that health insurance has been in existence it is truly remarkable that Blue Cross - Blue Shield and commercial insurance companies could have paid out in benefits an estimated total of six billion, 300 million dollars in 1961. This sum includes 855 million dollars in benefits for loss of income through injury or illness. In the first three months of 1962 there has been an increase of 93 million dollars in benefits over the corresponding period in 1961.

In 1958 the Council on Medical Service of the American Medical Association called a special meeting to discuss voluntary health insurance for the aged. During the 1958 Clinical Session of the AMA House of Delegates Supplementary Report "H" of the Council urged the medical profession to continue to assert its leadership in developing voluntary prepayment medical insurance . . . "for the group over 65 with modest resources or low family income." Within a year following this meeting the number of Medical Society sponsored Blue Shield plans, having initial enrollment for those over 65, increased from 9 to 33. Now there are 51 Blue Cross - Blue Shield plans in 41 states and the District of Columbia which have either removed enrollment restrictions or have special plans for those over 65 years of age. Also 41 medically sponsored plans now offer major hospital and medical expense benefits. Major medical coverage has been one of the fastest growing health insurance concepts in the insurance industry. Over 28,000,000 people are now enrolled in these extended coverage plans.

In addition to the Blue Cross Plans, the Health Insurance Institute reported that as of January 1, 1962, there were 81 insurance companies providing 157 "guaranteed for life" health insurance policies and plans for persons in or near retirement with most of the policies being available to anyone 65 years of age or older regardless of physical condition.

While both commercial companies and Blue Plans are constantly improving their coverage, physicians recognize that there exists a definite need to develop a nationally uniform comprehensive plan for our senior citizens at a premium they can afford to pay. Last January the Blue Cross Association in conjunction with the American Hospital Association, after a detailed study of the dimensions of the problem of financing health care of the aged, announced they were coming out with a new national plan for the over 65 group. Shortly thereafter the National Association of Blue Shield Plans and the American Medical Association made known they were working on a new plan for the aged. The target date for offering the Blue Cross Plan has been set for this month. Much work has been expended on the Blue Shield National Senior Citizen Plan and it likewise should be available soon. Boards of Directors of all West Virginia Blue Shield plans have approved this move and several have worked out their conversion factors whereby the Professional Service Index prepared by the National Association can be utilized to set up fee schedules applicable to local areas and situations.

To work out such a plan is not an easy task because many variables must be taken into consideration. For instance, five years were spent preparing the Federal Employee Health Benefits Program. We don't have this much time so we must redouble our efforts to implement a comprehensive National plan with all speed. Such a plan can be utilized by those senior citizens financially able to provide their own premiums as well as others who will require varying degrees of assistance. Such assistance shall not be provided through the Social Security System. The voluntary method is the logical approach and we are prepared to defend this concept without compromise. The insurance industry has the knowledge, experience and personnel to carry these programs forward in a most efficient manner and at much less cost to the American people. Legislation designed by the Congress to utilize these facilities will result in the best medical care for our people.

D. E. Greeneltch

D. E. Greeneltch, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 343-4607.

EDITORIALS

GUEST EDITORIAL

The relentless efforts of those forces dedicated to passage of a compulsory system of federally-controlled health services has commanded much of the Public Service Committee's attention during the past year. Because of the basic autonomy of each county medical society, public education concerning the threats posed by King-Anderson type legislation has been effectively accomplished by each society, in a manner tailored to its own individual needs, as judged by its own local membership. Other public service activities have not been neglected but have necessarily received far less publicity.

If nothing else has been accomplished by the "King-Anderson situation," it should have, by now, reminded doctors of the importance of attending their own medical meetings and participating, wherever possible, in civic affairs of their own community. Some of the doctors who complain the loudest about decisions made by committees of their local, state and national medical organizations, rarely attend a meeting.

Not long ago, Mr. John M. Bailey, Chairman of the Democratic National Committee, stated: "The self-perpetuating, bureaucratic dynasty that controls the AMA has stood for years against the social and economic advances . . ." Surely, Mr. Bailey was not speaking for the majority of the Democrats of this nation. In part, the reply of the Public Service Committee of the Ohio County Medical Society, which appeared in local newspapers read: "The major part of this 'self-perpetuating, bureaucratic dynasty' — the AMA House of Delegates — has had a 36 per cent turnover in the past three years. These delegates are elected in a democratic way by physician members of the AMA to represent them. This same group, through its leadership, has been in large measure directly responsible for the pre-eminence of American medicine in the world today."

On May 21, Dr. Edward R. Annis spoke on nationwide NBC television in reply to President Kennedy who supported the King-Anderson Bill at a senior citizen's rally in Madison Square Garden. Doctor Annis stated, in a portion of his presentation, that the AMA had never told its doctor members what to do. To my knowledge, this statement has not been challenged and I believe it is substantially correct.

Politicians trying to "push through" King-Anderson legislation have stooped to political smear attacks upon the AMA, while at the same time praising physicians as individuals. Such tactics are obviously ill-advised in the light of the fact that the AMA is nothing more or less than the physician members who compose it and the organization does represent 80 per cent of

the practicing medical doctors of America. The remaining 20 per cent are not members because they freely choose not to belong.

Events of the past year should indicate to all of us the necessity of running our own affairs, operating effective committees to handle complaints of patients and fellow doctors and realistically cooperating with local, state and national health organizations. If the doctors cannot run their own affairs, censure their own members where indicated, and integrate their medical activities with other community functions, someone outside the medical profession is certain to do these things for them. Those of us who "do not have time" may well have their time scheduled for them by government clerks directed by politicians who are, in turn, appointed by political pressure groups.

It is sheer nonsense and deliberate political deception for the Administration or any other group to cite the documented support of a tiny segment of the AMA membership (less than 1 per cent) and to imply that this group represents a significant opinion of the AMA physician members. If this tiny group of doctors prefer socialism to freedom, that is their privilege, but it is not the privilege of anyone in America to quote this small group as representing an opinion supposedly superior to the overwhelming majority of our AMA membership.

Proponents of a compulsory system of federally-administered health services can afford to lose many battles. Physicians and all other citizens interested in the preservation of high quality medical care, basic freedoms and freedom of enterprise in America must realize that the loss of one battle may well mean loss of the war.

We urge you once again to write your Senators and Congressmen for the purpose of letting them know exactly where you stand on this vitally important issue. It is equally important that you ask your patients and friends to write letters voicing disapproval of King-Anderson legislation.

Dr. Ernest B. Howard has pointed out that the doctors of America see 2,000,000 patients every day. It is the responsibility of members of both major political parties to maintain an active interest in preserving individual freedom and the individual spirit of initiative and responsibility which have made this country the envy of the world.—*Guest Editorial by Joseph L. Curry, M. D., Chairman, Public Service Committee, West Virginia State Medical Association.*

THE CEREBRAL CIRCULATION

The importance of the blood supply to the brain need not be emphasized. Just how the circulation is regulated in the brain is as yet not fully understood, but certain new concepts have developed during the past decade or so which merit attention. The circulation in the brain first received serious consideration in 1783 when Monro[1] pointed out that because the skull was rigid and its contents incompressible the blood volume of the brain was fixed, so that there could be no variation in blood flow. This idea went unchallenged for more than 100 years.

Hill,[2] in 1896, reported extensive experimental studies on cerebral flow in animals. He concluded that the blood flow in the brain was variable, but passively so in that it was governed by the systemic arterial and venous pressures. His work was accepted for more than a quarter of a century and, indeed, was widely quoted in most of the textbooks of physiology and of neurology. Many practitioners of medicine today may still have this concept which they learned in medical school.

Forbes,[3] in 1940, was among the first to call attention to the fact that there was an intrinsic control of the cerebral circulation. Kety[4] recently has ably reviewed the cerebral circulation in man. Among the intrinsic factors he mentions are: the oxygen and the carbon dioxide tension in the blood, the narrowing or dilatation of the cerebral vessels, the viscosity of the blood, the variations of the intracranial pressure, and the neurogenic control of the cerebral blood vessels. It is beyond the scope of this discussion to comment on all of these intrinsic factors, except to emphasize the importance of the oxygen and carbon dioxide tension in the blood, and also to point out that neurogenic control presumably is not a very important factor.

The general belief is that the brain has an extraordinarily rich blood supply. This is only relatively true; for example, the capillary circulation in the cortex of the brain is about 500 capillaries per mm^2 of cross section (in the white matter the value is about 300). In the myocardium, however, there is a much richer capillary supply—in the order of about 5,000 capillaries per mm^2. As far as it is known the vascular structure in the brain reveals no evidence of arteriovenous anastomosis.

It is worthwhile to mention briefly the cerebral circulation during certain physiologic states. In normal sleep there is no significant decrease in cerebral circulation, indeed, there may be a

slight increase. Obviously, the theory, which once held vogue, that sleep is caused by ischemia of the cortex of the brain, is no longer tenable. The cerebral exertion required in the performance of mental arithmetic is not associated with any significant changes in blood flow or oxygen consumption in the brain. It should be pointed out, however, that there is evidence that there may be an effect locally with a change in activity; for example, it has been shown that stimulation of the retina produces an increase in blood flow in the visual cortex.

In abnormal states, such as cerebral arteriosclerosis, it has been demonstrated that there is a decrease in cerebral circulation and in oxygen consumption. This would be anticipated. In essential hypertension, although there is an increase in tone of the cerebral vessels, akin to the increased tone in the systemic vessels, the cerebral circulation stays within normal limits. The cerebral blood flow has also been studied in epilepsy, schizophrenia, and in multiple sclerosis. In none of these diseases has there been found a significant change in the blood flow from the normal or expected value.

The matter of age in connection with cerebral circulation is worthy of comment. It is well known that there is a high rate of blood flow in the brain during the first decade of life. About the time of puberty, however, the blood flow reaches approximately the value of the young adult. There is presumably a general feeling that as age advances the cerebral circulation is progressively diminished, and that this accounts for the loss of memory in older people, and certain other manifestations associated with age. It is gratifying to older people that Sokoloff[5] has reported that in a carefully selected age group, who all were in good mental and physical health, that the cerebral blood flow did not differ significantly from the normal young adult.

In summary, the old theory, then, that the cerebral circulation is entirely at the command of the general circulation is no longer tenable. It is regulated largely by intrinsic factors, which makes the brain more responsive to the local needs, and obviously can serve more efficiently the economy of the body.

1. Monro, A., Observations on the Structure and Functions of the Nervous System. Edinburgh, Creech, 1783.
2. Hill, L., The Physiology and Pathology of the Cerebral Circulation. London: Churchill, 1896.
3. Forbes, H. S., A.M.A. Arch. Neurol. & Psychiat., 43, 804, 1940.
4. Kety, S. S., Handbook of Physiology (Section 1, Neurophysiology) 3:1751, 1960.
5. Sokoloff, L., Proc. Conference on the Process of Aging on the Nervous System. Springfield, Ill., Thomas, 1959.

WHAT IS MEDICARE?

A lot of people are asking what "Medicare" is and I am telling them. Do you know Jack Martin who lives over beyond Nettie? Fellow with a farm, worked in the mines until the mines worked out, saved his money. Well heeled. And old Ebenezer Scrooge, the lawyer, who has pinched pennies for nigh on to fifty years and owns enough AT&T stock certificates to paper a room with?

Well, the government is asking Bronson and me to get out and stimulate advertising and subscriptions so that we can pay out $12 a year each to take care of Jack and that skinflint Ebenezer. It is also asking that we increase our employees so that they can each pay $12 a year on those two guys' hospital stay. And then the government is asking us to pick things up so that we can toss in an extra $12 a year to match our employees' twelve bucks.

That's what this so called Medicare is. Old Jack and Eb can go to the hospital for a while or to a nursing home because they are past 65. The plan won't pay for the doctor who takes care of them. They'll have to wait four or five years for that, until the government gets the gall to ask for another 12 bucks a year. And it doesn't pay for medicine or shots or things like that. Jack and Eb will maybe have to wait eight or nine more years until Uncle Sam asks Bronson and me to ante up another $12. By that time Jack and Eb will be dead. But there will be others.

I often wonder when people will learn that a government is not capable of generating wealth, that what it gives for a vote must be taken from the voter. I wonder, too, if they think the voter can generate wealth from any source except from his fellow voters. The only medical care that the government should give is to a person, old or young, who is without funds and without near kin. It is only people of low character who would toss his old folks upon strangers anyhow.—*Jim Comstock, in The West Virginia Hillbilly.*

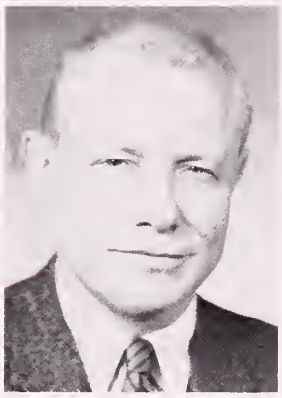
Columnist Raymond Moley has recalled a statement made by Britain's Aneurin Bevan in February, 1950. When asked how he intended to get control of the British Medical Association, Bevan, who was then Minister of Health, said: "We have got the hospitals, and that means we will control the doctors. They can't practice without places to practice."

It is well to note that H. R. 4222 would control hospitals, and Mr. Bevan's words only confirm medicine's contention that the bill would place controls over the practice of medicine.—Virginia Medical Monthly.

GENERAL NEWS

Program Completed for Annual Meeting At The Greenbrier, Aug. 23-25

The program has been completed for the three general scientific sessions which will be held during the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25.



John W. Hope, M. D.

James G. Hughes, M. D.

Dr. Halvard Wanger of Shepherdstown, Chairman of the Program Committee, said that Drs. John W. Hope of Philadelphia, Otto C. Phillips of Pittsburgh and James G. Hughes of Memphis, Tennessee, have been added to the list of prominent physicians and surgeons who have accepted invitations to present papers during the three-day meeting.

Doctor Hope, who is Director of the Department of Radiology at the Children's Hospital of Philadelphia and Professor of Clinical Radiology at the University of Pennsylvania School of Medicine and Graduate School of Medicine, will appear as a speaker at the third general scientific session on Saturday morning, August 25. His subject will be "Roentgen Facts and Fallacies Regarding the Chest of Infants and Children."

He was born in Chicago and received his M. D. degree from Stanford University School of Medicine in 1940. He served residencies at Stanford Lane Hospital, 1940-42, and at the Graduate School of Medicine and Hospital of the University of Pennsylvania, 1947-50. He served with the Medical Corps of the United States Navy, 1942-47, and was released with the rank of Lieutenant Commander. He was certified by the American Board of Radiology in 1950.

Doctor Hope is a Fellow of the American College of Radiology and is a member of the Radiological Society of North America, the American Roentgen Ray Society, and serves as a consultant in radiology to several hospitals in the Philadelphia area.

Otto C. Phillips, M. D.

Dr. Otto C. Phillips, who is Professor of Anesthesiology at the University of Pittsburgh School of Medicine, will appear as a speaker during the first general scientific session on Thursday morning, August 23. His subject will be "Factors in Obstetrical Mortality: The Role of Anesthesia."

He is a native of Baltimore and received his M. D. degree from the University of Maryland School of Medicine in 1942. He served his internship at St. Joseph's Hospital in Baltimore, 1942-43, and was graduated in 1945 from the School of Aviation Medicine at Randolph Field in Texas.

Doctor Phillips served a residency in surgery at the Maryland General Hospital in Baltimore, 1946-47, and served as a Fellow in Anesthesia at the Lahey Clinic in Boston, 1947-49. He served as assistant professor of clinical anesthesia at the University of Maryland School of Medicine, 1955-61, and also served during the same period as chief of anesthesia at the Hospital for the Women of Maryland in Baltimore. In addition to his present duties at the University of Pittsburgh, he is also serving as chief of anesthesia at the Elizabeth Steel Magee Hospital in that city.

He is a Diplomate of the American Board of Anesthesiology and has served since 1954 as Chairman of the Baltimore Anesthesia Study Committee. He served as President of the Maryland Society of Anesthesiologists, 1956-57, and as chairman of the maternal welfare committee of the American Society of Anesthesiologists, 1960-61.

James G. Hughes, M. D.

Dr. James G. Hughes, who is Professor and Head of the Division of Pediatrics at the University of Tennessee College of Medicine in Memphis, will appear as a speaker during the third general scientific session on Saturday morning, August 25. His subject will be "Epilepsy in Children."

He was born in Memphis and received his M. D. degree from the University of Tennessee College of Medicine in 1935. He interned at John Gaston Hospital in Memphis, 1935-37, and served residencies in pediatrics at that hospital and the Children's Memorial Hospital in Chicago, 1937-39.

He served with the Medical Corps of the United States Army during World War II and was released with the rank of Colonel. He served as assistant and

associate professor of pediatrics and was named professor in 1952 at the University of Tennessee College of Medicine. He was named Head of the Division in 1960.

Doctor Hughes is the author of "Pediatrics in General Practice" published in 1952, and he is currently writing "Synopsis of Pediatrics."

He is a Diplomate of the American Board of Pediatrics and has served as Chairman of the Committee on Medical Education of the American Academy of Pediatrics.

First General Session

The program committee announced previously that Surgeon General Leonard D. Heaton will be among the honored guests and will present an address at the opening of the first general scientific session on Thursday morning, August 23.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25, 1962.

A cordial invitation to attend all sessions has been extended by the Program Committee to interns and physicians serving a residency in hospitals in West Virginia and adjacent states.

Requests for hotel accommodations should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs.

The other speakers and their subjects at the first general session will be as follows:

I. S. Ravdin, M. D., Professor of Surgery and Vice President of Medical Affairs, University of Pennsylvania, Philadelphia. Subject: "Cancer Chemotherapy."

Alfred E. Maumenee, M. D., Professor of Ophthalmology, Johns Hopkins University School of Medicine, Baltimore. Subject: "Ocular Manifestations of General Medical Disease."

Otto C. Phillips, M. D., Professor of Anesthesiology, University of Pittsburgh School of Medicine, Pittsburgh. Subject: "Factors in Obstetrical Mortality: The Role of Anesthesia."

Second General Session

The second general scientific session will be held on Friday morning, August 24. The speakers and their subjects will be as follows:

William S. Middleton, M. D., Chief Medical Director, Veterans Administration, Washington, D. C., and Dean Emeritus and Professor of Medicine Emeritus, University of Wisconsin Medical School. Subject: "Abdominal Angina."

Irving S. Wright, M. D., Professor of Clinical Medicine, Cornell University Medical College, New York City. Subject: "The Modern Treatment of Cerebrovascular Diseases."

Stewart G. Wolf, M. D., Professor and Head, Department of Medicine, University of Oklahoma School of Medicine, Oklahoma City. Subject: "The Relation of Life Stress to Serum Lipids in Patients with Coronary Artery Disease."

Third General Session

The third general scientific session will be held on Saturday morning, August 25, and the following program presented:

James G. Hughes, M. D., Professor of Pediatrics, University of Tennessee College of Medicine, Memphis. Subject: "Epilepsy in Children."

John W. Hope, M. D., Director, Department of Radiology, The Children's Hospital of Philadelphia. Subject: "Roentgen Facts and Fallacies Regarding the Chest of Infants and Children."

H. L. Riva, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, Seton Hall College of Medicine, Jersey City, New Jersey. Subject: "Preventive Medical Measures in Obstetrics and Gynecology."

Doctor Wanger and the other two members of the Program Committee, Drs. Charles D. Hershey of Wheeling and George P. Heffner of Charleston, will serve as moderators and will introduce the speakers at the morning sessions.

All of the speakers have accepted invitations to present papers before afternoon meetings of the Association's sections and affiliated societies and associations.

Honor Guests on Program

In addition to an address by General Heaton, Doctor Wanger also announced that Dr. George M. Fister of Ogden, Utah, President of the American Medical Association, will attend the meeting and speak before the second session of the House of Delegates on Saturday afternoon, August 25.

Dr. D. E. Greeneltch of Wheeling, President of the State Medical Association, will deliver his Presidential Address at the first session of the House of Delegates on Wednesday evening, August 22.

Heavy Advance Registration

The number of reservations for rooms at The Greenbrier during the annual meeting in August has passed the 450 mark and it is anticipated that more than eight hundred persons, including physicians, their wives and guests, will be in attendance.

All physicians who plan to attend the meeting are urged to make reservations as soon as possible. An early request will assure physicians, their families and guests of room accommodations.

The complete program for the meeting will appear in the August issue of *The West Virginia Medical Journal.*

Relocations

Dr. William E. Christie, Jr., of Elkins, has moved to Pittsburgh and his office address in that city is 822 Flemington Street.

14 Men and One Woman Receive First M. D. Degrees at WVU

Fourteen young men and one woman received the first M. D. degrees from the West Virginia University School of Medicine at the 93rd WVU Commencement in Morgantown on June 4.

The official beginning of the University's four-year medical program dates back to 1951 when the Legislature passed a measure providing for "a four-year school of medicine, dentistry and nursing at West Virginia University."

The bill itself was the result of years of preliminary preparation and study by many groups and organizations, the most active of which was the West Virginia State Medical Association.

Ground was broken for the Medical Center on December 9, 1952. Virtually the entire construction cost as well as the cost of maintenance and operation has come from a one-cent tax on each bottle of soft drinks sold in West Virginia.

All 15 graduates have been accepted for internships —13 in their "first choice" hospitals. Five members will intern in West Virginia hospitals, five will go into the armed services, and the remaining five will intern in hospitals in other sections of the United States.

Members of the class, their hometowns and places of internship follow:

Bridgeport—David L. White, Mound Park Hospital, St. Petersburg, Florida.

Burlington—Joseph B. Reed, Memorial Hospital, Charleston.

Charleston—Jesse S. Griffith, Charleston General Hospital; and Halbert E. Ashworth, U. S. Naval Hospital, Pensacola, Florida.

Clarksburg—Charles L. Ladwig, George Washington Medical Center, Washington, D. C.

Clendenin—Francis A. Goad, West Virginia University Hospital.

Fairmont—Joseph A. Ruggiero, U. S. Naval Hospital, Bethesda, Maryland.

Huntington—Richard A. Arnold, Queen's Hospital, Honolulu, Hawaii; and Charles W. Lewis, Fitzsimons U. S. Army Hospital, Denver, Colorado.

Morgantown—George H. Nelson, Medical College of Georgia, Talmadge Hospital, Augusta, Georgia; and Kenneta J. Shaffer, University of Kansas Hospital, Kansas City, Kansas.

Meadow Bridge—Louis Groves, Jr., Memorial Hospital, Charleston.

Nitro—Frederick Cooley, Memorial Hospital, Charleston.

St. Marys—Larry Hemmings, U. S. Naval Hospital, Bethesda, Maryland.

Webster Springs—Basil D. Cutlip, U. S. Air Force Hospital, Lackland Air Force Base, San Antonio, Texas.

Medical Meetings, 1962

The following is a partial list of national, state and district medical meetings scheduled for 1962:

Aug. 16-18—W. Va. Hospital Assn., White Sul. Springs.
Aug. 23-25—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 9-15—Dermatology Congress, Washington.
Sept. 13-16—PG Institute, Martinsburg.
Sept. 17-20—American Hospital Assn., Chicago.
Sept. 20-21—W. Va. Heart Assn., Morgantown.
Oct. 1-4—Interstate PG Assembly, Chicago.
Oct. 4-6—Congress on Mental Illness, Chicago.
Oct. 9-11—W. Va. TB and Health Assn., Beckley.
Oct. 15-19—ACS Clinical Congress, Atlantic City.
Oct. 22-23—American Cancer Soc., New York.
Nov. 2-4—ACP Regional Meeting, White Sul. Springs.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 24-25—ACCP, Ambassador Hotel, Los Angeles.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.

The first graduates of the West Virginia University School of Medicine are shown with Dean Clark K. Sleeth. The 14 men and one woman received their M. D. degrees June 4. Seated, left to right, are David L. White of Bridgeport; Kenneta J. Shaffer of Morgantown; Dean Sleeth; Joseph B. Reed of Burlington; and George H. Nelson of Morgantown. Standing: Frederick Cooley of Nitro; Charles W. Lewis of Huntington; Joseph A. Ruggiero of Fairmont; Basil D. Cutlip of Webster Springs; Jesse S. Griffith of Charleston; Richard B. Arnold of Huntington; Larry Hemmings of St. Marys; Charles L. Ladwig of Clarksburg; Louis Groves, Jr., of Meadow Bridge; Halbert E. Ashworth of Charleston; and Francis A. Goad of Clendenin.

New Association Members

Dr. Robert A. Dye, The Wheeling Clinic, Wheeling (Ohio). Doctor Dye, a native of Morgantown, attended the two-year School of Medicine at West Virginia University and received his M. D. degree from the University of Pennsylvania School of Medicine in 1956. He interned in Detroit and served a residency at the Kresge Eye Institute of Wayne State University, 1957-58. He served with the United States Navy during World War II and was previously located at Marshfield, Wisconsin. His specialty is ophthalmology.

* * * *

Dr. Donald L. Glynn, Man Memorial Hospital, Man (Logan). Doctor Glynn was born in Berwick, Pennsylvania, and was graduated from Swarthmore College. He received his M. D. degree in 1939 from the University of Pennsylvania School of Medicine, and served his internship at Geisinger Memorial Hospital, 1939-40. He served residencies at Geisinger and the Mayo Clinic, 1940-45, and was located previously in Philadelphia and Urbana, Illinois. His specialty is internal medicine.

* * * *

Dr. Ray A. Harron, 101 Philadelphia Avenue, Bridgeport (Harrison). Doctor Harron, a native of Chicago, was graduated from Iona College and received his M. D. degree from the New York Medical College in 1957. He interned at the USPHS Hospital, Staten Island, New York, 1957-58, and served residencies at that hospital and at Charity Hospital in New Orleans, 1958-61. His specialty is radiology.

* * * *

Dr. William J. Kucewicz, 320 Front Street, Bridgeport (Harrison). Doctor Kucewicz was born in Yonkers, New York, and was graduated from Fordham University. He received his M. D. degree from St. Louis University in 1936 and served an internship at Meriden Hospital, 1936-37. He served a residency at Maryview Hospital in Portsmouth, Virginia, 1958-61, and he was located previously in Norfolk, Virginia. His specialty is pathology.

* * * *

Dr. Stephen D. Ward, The Wheeling Clinic, Wheeling (Ohio). Doctor Ward, a native of Pittsburgh, was graduated from the University of Pittsburgh and received his M. D. degree in 1954 from the University of Pittsburgh School of Medicine. He interned at Mercy Hospital in Pittsburgh, 1954-55, and served a residency at the Western Psychiatric Institute and Clinic, University of Pittsburgh, 1955-58. His specialty is psychiatry.

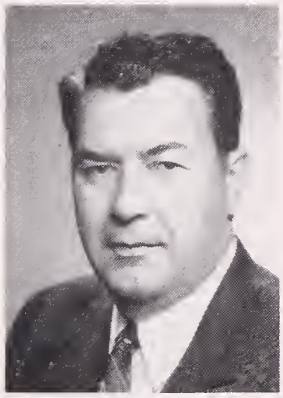
Rheumatic Fever Prevention Program

More than 1,600 people in West Virginia have received free penicillin through the rheumatic fever prevention program of the West Virginia Heart Association and the State Department of Health.

The penicillin is available to medically indigent patients. It is distributed to persons, mostly children, who have had a known attack of rheumatic fever or who have known rheumatic heart disease or cardiac surgery or congenital heart disease of such magnitude that the referring physician deems prophylaxis advisable.

Dr. Charles A. Hoffman Reelected Treasurer of AUA

Dr. Charles A. Hoffman of Huntington was reelected treasurer of the American Urological Association during the 57th Annual Meeting of that organization which was held at the Bellevue-Stratford Hotel in Philadelphia, May 14-17.



Charles A. Hoffman, M. D.

Doctor Hoffman has been active for many years in the AUA and served for three years as Chairman of the Public Relations Committee. He is a past president of the Mid-Atlantic Section of the AUA.

He is a past president of the West Virginia State Medical Association and is currently serving as one of the two state delegates to the American Medical Association. Doctor Hoffman also is Chairman of the Insurance Committee of the State Medical Association.

Frequent Use of Cancer Registry Urged by State Committee

Frequent use by doctors of the Cancer Registry in West Virginia hospitals has been urged by the Cancer Committee of the West Virginia State Medical Association.

In a recent letter to physicians, Dr. John T. Jarrett of Charleston, committee chairman, said the accumulated information and regular follow-up of patients makes possible definite reports to the medical staff of their accomplishments as well as reports for special study.

Doctor Jarrett said the State Division of Vital Statistics has made available for many years information about deaths caused by cancer, but that cancer registries now provide information about the living.

"Our goal is to increase the number of living cancer patients," he said. "And the cancer registry can be a living part of your hospital but to be effective it must have:

"1. Interest of the medical staff in the results of their treatment of cancer.

"2. Desire of the medical staff to evaluate constantly the effectiveness of their diagnoses and treatment.

"3. Willingness of the medical staff to support this method of bringing constant evaluation into reality."

The American College of Surgeons made it mandatory after December 31, 1955, for hospitals conducting cancer clinics and diagnostic clinics to have as a part of their program a cancer registry. With the establishment of the Central Cancer Registry in the State Department of Health in 1957, all West Virginia hospitals treating cancer patients have been reporting and keeping a file of such cases.

Doctor Benson Installed as President Of W. Va. Chapter, AAGP

Dr. Don S. Benson of Moundsville was installed as President of the West Virginia Chapter of the American Academy of General Practice during the 10th Annual Scientific Assembly which was held at the Civic Center in Charleston, May 25-27.

Doctor Benson succeeds Dr. Randall Connolly of Vienna, who will serve as Chairman of the Board of Directors during the coming year.

Dr. Joseph A. Smith of Dunbar was named president elect and will assume his duties as president at the annual meeting in Charleston next May.

New officers of the West Virginia Chapter of the American Academy of General Practice are shown following their election at the Tenth Annual Scientific Assembly at the Civic Center in Charleston, May 25-27. Left to right, Dr. Don S. Benson of Moundsville, president; Dr. Joseph A. Smith of Dunbar (standing), president elect; Dr. Jack Leckie of Huntington, vice president; Dr. Peter A. Haley of Charleston, secretary; Dr. Randall Connolly of Vienna (standing), retiring president; and Dr. L. Dale Simmons of Clarksburg, treasurer. (Photo courtesy of The Charleston Gazette).

Other officers were elected as follows:

Dr. Jack Leckie of Huntington, vice president; Dr. Peter A. Haley of Charleston, secretary; and Dr. L. Dale Simmons of Clarksburg, treasurer. Drs. Frank M. Booth of Huntington, Everett B. Wray of Beckley, and Joe N. Jarrett of Oak Hill were named members of the Board of Directors.

Native of Tennessee

Doctor Benson, the new president, is a native of Dayton, Tennessee, and was graduated from the University of Tennessee. He received his M. D. degree from the University of Tennessee College of Medicine in 1930, and served an internship at Wheeling Hospital in Wheeling and a residency at Ohio Valley Hospital in Steubenville, Ohio.

Doctor Benson had served two terms as vice president of the Academy and was named president elect at the annual meeting in 1961.

He is also a member of the Marshall County Medical Society, West Virginia State Medical Association and the American Medical Association.

More than 200 physicians attended scientific sessions which were held during the three-day meeting at the Civic Center in Charleston. Doctor Benson served as general chairman and the members of the program committee were Dr. Halvard Wanger of Shepherdstown, chairman, and Drs. Clark K. Sleeth of Morgantown and Carl B. Hall of Charleston.

Dr. William D. Crigger of South Charleston was in charge of local arrangements, and Dr. Martha Jane Coyner of Harrisville served as chairman of the scientific exhibit committee.

Doctor Connolly called the meeting to order officially on Friday afternoon, May 25. The invocation was given by the Rev. John S. Lyles of Dunbar and addresses of welcome were delivered by the Hon. John A. Shanklin, Mayor of Charleston. Dr. D. E. Greeneltch of Wheeling, President of the West Virginia State Medical Association, and Dr. Robert C. Bock of Charleston, President of the Kanawha County Medical Society.

The scientific session that afternoon was devoted to a program sponsored by the West Virginia Heart Association.

Eighteen Guest Speakers

Eighteen prominent physicians and surgeons appeared as guest speakers at the scientific sessions held during the meeting. Moderators were Drs. Sleeth of Morgantown, Carl B. Hall of Charleston, Jerome C. Arnett of Rowlesburg, and Jack Leckie of Huntington.

Doctor Connolly presented his presidential address at a session of the Academy's House of Delegates which was held at the Civic Center on Friday morning, May 25.

The delegates reaffirmed their opposition to enactment of the King-Anderson bill or other legislation which would place medical care for the aged under Social Security. Dr. J. Keith Pickens of Clarksburg, retiring chairman of the Board, said "care of the aged is near and dear to the hearts of all of us. We simply believe that it can be done more efficiently and economically under the present law (Kerr-Mills) if it is properly implemented."

It was also announced during the meeting that the 11th Annual Scientific Assembly will be held in Charleston, May 24-26, 1963. Dr. Richard E. Flood of Weirton was named chairman of the Program Committee.

Doctor Leake Banquet Speaker

Dr. Chauncey D. Leake, Professor of Pharmacology at the Ohio State University College of Medicine, was the guest speaker at the banquet which was held at the Civic Center on Saturday evening. His subject was "Standards of Measurements and Nursery Rhymes."

Dr. William Paul Bradford of Moundsville served as toastmaster for the banquet which was preceded by a social hour. The Past President's Key was presented to Doctor Connolly by Dr. J. Keith Pickens of Clarksburg, a past president of the Academy.

Mrs. Joseph A. Smith of Dunbar was in charge of the entertainment program for wives of physicians in attendance at the meeting. Serving on the committee with her were Mesdames Edward Jackson of St. Albans, William C. Polsue of Charleston, Paul Totten of St. Albans and John W. Hash of Charleston.

Interstate Postgraduate Assembly In Chicago, October 1-4

The 47th annual Scientific Assembly of the Interstate Postgraduate Association will be held at the Palmer House in Chicago, October 1-4.

The program is especially suited to the needs of generalists, as all lectures, panels and clinics are closely related to medical problems familiar to the physician who does not devote his time to a single speciality.

Panels on "Arthritis," "Tranquilizers and Energizers," and the "Medical and Surgical Treatment of Duodenal Ulcers" will be included in the program. A special program also has been arranged for wives of physicians attending the meeting.

Further information concerning the program and hotel accomodations may be obtained by writing to N. A. Hill, M. D., Secretary, Interstate Postgraduate Association, Box 1109, Madison 1, Wisconsin.

International Dermatology Congress In Washington, September 9-15

More than 350 dermatologists from 41 countries will participate in the 12th International Congress of Dermatology in Washington, September 9-15.

Dr. Donald M. Pillsbury of Philadelphia, President of the Congress and Chairman of the Department of Dermatology at the University of Pennsylvania School of Medicine, said the core of the program will be 15 symposia designed to apply advances in basic sciences to clinical dermatology.

Three teams of simultaneous translators will function throughout the meeting to be held at the Shoreham and Sheraton Park Hotels. This will enable physicians to hear most of the offerings in either English, French, German or Spanish, the official languages of the Congress.

Interim Meeting of NNP Section At WVU Medical Center

Thirty five members and guests attended an interim meeting of the Section on Neurology, Neurosurgery and Psychiatry of the State Medical Association which was held at the West Virginia University Medical Center in Morgantown on May 12.

The scientific program was presented by members of the faculty of the School of Medicine and a tour of the Medical Center was conducted by Dean Clark K. Sleeth.

The following scientific program was presented in connection with the one-day meeting:

"Hormonal Changes in Psychogenic Amenorrhea."—Thomas Loftus, M.D., Professor and Head of the Department of Psychiatry.

"Total Cerebral Blood Flow and Oxygen Consumption Using Dye Dilution Method."—Byron M. Bloor, M.D., Chief of the Division of Neurological Surgery.

"Parkinson's Disease and Its Surgical Treatment."—George R. Nugent, M.D., Division of Neurological Surgery.

"Electromyography and Related Procedures."—John W. Nelson, M.D., Assistant Professor of Medicine (Neurology).

A meeting of the Section will be held in connection with the annual meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25. The guest speaker will be Dr. Stewart G. Wolf, Professor and Head of the Department of Medicine at the University of Oklahoma School of Medicine.

A man who uses a great many words to express his meaning is like a bad marksman who instead of aiming a single stone at an object takes up a handful and throws at it in hopes he may hit.—Samuel Johnson.

Dr. Chauncey D. Leake, center, Professor of Pharmacology at Ohio State University, was the speaker at a banquet held in connection with the 10th Annual Scientific Assembly of the West Virginia Chapter, AAGP. Shown with him are Dr. E. J. Van Liere, Dean Emeritus of the West Virginia University School of Medicine, and his successor, Dean Clark K. Sleeth. In the other photo, Drs. Charles A. Doan of Columbus, Ohio, and O. Spurgeon English of Philadelphia, are shown with Dr. Halvard Wanger of Shepherdstown, chairman of the program committee.

Mrs. Bette Hicks New President Of Medical Assistants Assn.

Mrs. Bette Hicks of St. Albans was installed as president of the West Virginia Association of Medical Assistants during the annual meeting at the Beckley-Winn Hotel in Beckley, May 19-20. She succeeds Mrs. Mary Ellen Kessler of Beckley.

Mrs. Eulalia Hanly of Charleston was named president elect, Mrs. Mary Marchun of Charleston, vice president, Mrs. Rhodie Rhodemyre of St. Albans, secretary, and Mrs. Dora DeHart of Beckley, treasurer. Dr. W. Fred Richmond of Beckley was the installing officer.

Mrs. Hicks and Mrs. Hanly also were named delegates to the American Association of Medical Assistants convention in Detroit, September 27-30. Mrs. Juanita Rauch of Parkersburg is the alternate.

William H. Lively of Charleston, executive secretary of the West Virginia State Medical Association, delivered the opening address at the two-day meeting.

Dr. John A. Hedrick of Beckley, president of the Raleigh County Medical Society, delivered an address on the merits of the present Kerr-Mills MAA program as opposed to the proposed King-Anderson legislation. Governor W. W. Barron honored the association by proclaiming the week of its meeting as "Medical Assistants Week" in West Virginia.

Special Meeting in Kingwood

Dr. A. L. Chapman was the principal speaker at a special meeting of the Preston County Medical Society which was held at the Preston Country Club near Kingwood on June 28.

Doctor Chapman, who is Assistant Surgeon General and Chief of the Division of Accident Prevention, Department of Health, Education and Welfare, delivered an address at the banquet which was held in connection with the one-day meeting.

MLB Licenses 12 Physicians To Practice in State

The Medical Licensing Board has announced that 12 physicians have been licensed by reciprocity to practice medicine in West Virginia. The Board met in Charleston on April 30.

The following is a list of physicians licensed by reciprocity:

Brown, Hugh Michael, Clarksburg
Haley, Raymond Carter, Jr., Williamson
Housman, John Harold, Manheim, Pa.
Hunter, Murray B., Fairmont
Kindschi, Donald Rex, Williamson
Loftus, Thomas Anthony, Morgantown

Skitarelic, Benedict, Cumberland, Md.
Tarnay, Thomas Joseph, Morgantown
Vance, Thomas Doyle, Beckley
Voss, Edward C., Jr., Wheeling
Horwitz, Frederick, Man
Brooks, James Locke, Jr., Mt. Morris, Pa.

The summer meeting of the Medical Licensing Board will be held in Charleston, July 23-25, 1962, for the purpose of examining applicants for licensure to practice medicine in West Virginia.

PG Course in Gastroenterology

The annual course in postgraduate gastroenterology, sponsored by the American College of Gastroenterology, will be held at the Morrison Hotel in Chicago, November 1-3.

Moderators for the course will be Dr. Owen H. Wangensteen of Minneapolis, and Dr. I. Snapper of Brooklyn, New York. The faculty will be drawn from the medical schools in and around Chicago.

Further information may be obtained by writing the American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

New officers of the West Virginia Association of Medical Assistants are shown following their installation at the annual meeting at Beckley, May 19-20. Left to right, Mrs. Dora Dellart of Beckley, treasurer; Mrs. Eulalia Hanly of Charleston, president elect; Mrs. Bette Hicks of St. Albans, president; Mrs. Mary Marchun of Charleston, vice president; and Mrs. Rhodie Rhodemyre of St. Albans, secretary.

Fifteen West Virginia Students Graduate From MCV

Fifteen students from West Virginia received M. D. degrees from the Medical College of Virginia during the 125th Commencement Exercises held at The Mosque, in Richmond, on June 3, 1962.

The following is a list of West Virginia graduates with hospital appointments for 1962-63:

Bowman, Robert Lee, Morgantown
U. S. Naval Hospital
Philadelphia, Pennsylvania

Carter, Tom Eustace, Huntington
New England Center Hospital
Boston, Massachusetts

Fisher, Gilbert Franklin, Jr., Huntington
Johnston-Willis Hospital
Richmond, Virginia

Gaziano, Dominic, Pemberton
Johnston-Willis Hospital
Richmond, Virginia

Jordan, William Gregor, Oak Hill
University of Alberta Hospital
Edmonton, Alberta, Canada

Julias, George Stephen, Martinsburg
Medical College of Virginia Hospitals
Richmond, Virginia

Kern, Marguerite Ann, Beckley
Medical College of Virginia Hospitals
Richmond, Virginia

Mosrie, Azett Jimmie, Princeton
Mercy Hospital
Springfield, Ohio

Moss, Hubert Vencill, Weirton
Medical College of Virginia Hospitals
Richmond, Virginia

Rashid, Charles Richard, Charleston
Mercy Hospital
Springfield, Ohio

Schmid, William Henry, Benwood
University of British Columbia Hospital
Vancouver, British Columbia, Canada

Steele, Ida May Hogshead, Montgomery
Lewis-Gale Hospital
Roanoke, Virginia

Steele, James Lebrect, Montgomery
Lewis-Gale Hospital
Roanoke, Virginia

Stephens, Pete Louis, Weirton
Miami Valley Hospital
Dayton, Ohio

Zakaib, Edward Albert, Charleston
Johnston-Willis Hospital
Richmond, Virginia

New Film on Strokes

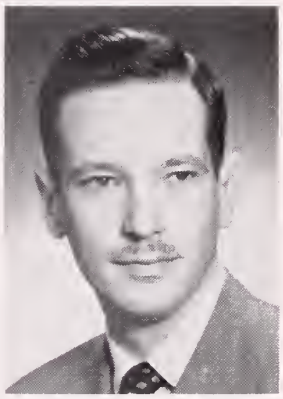
A new professional film, "Cerebral Vascular Diseases: The Challenge of Diagnosis," has been produced by the American Heart Association and is available for showings before meetings of component medical societies. Contact the West Virginia Heart Association, Box 5336, Capitol Station, Charleston, W. Va.

Three Guest Speakers To Appear On Allergy Program

Three prominent physicians have accepted invitations to appear as guest speakers before an open meeting of the West Virginia State Society of Allergy, which will be held during the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25.

Dr. Merle S. Scherr of Charleston, secretary of the Society, announced that Dr. William A. Hopkins of Atlanta, Georgia, Dr. Gustav J. Beck of New York City, and Dr. Irving W. Schiller of Boston, will present papers at the meeting which will be held on Thursday afternoon, August 23.

Irving W. Schiller, M. D.



Gustav J. Beck, M. D.

Doctor Hopkins, who is instructor in thoracic surgery at Emory University School of Medicine, will present a paper on "Chronic Lung Disease: Group and Clinic Therapy."

Doctor Hopkins is president of the Georgia Trudeau Society and is also attending thoracic surgeon at Grady Memorial Hospital in Atlanta.

Doctor Beck, who is a native of Vienna, Austria, is instructor in medicine at the Columbia University College of Physicians and Surgeons in New York City. He will present a paper on "Physiologic Considerations in the Management of Bronchial Asthma and Pulmonary Emphysema." He was awarded a Certificate of Merit by the American Medical Association in 1955.

Doctor Schiller will present a paper on "A Brief Review of Drug Therapy in Bronchial Asthma." He is associate clinical professor of medicine at Tufts University School of Medicine and co-physician-in-chief of the Allergy Clinic at the Boston Dispensary-New England Medical Center.

Doctor Scherr will serve as moderator of a panel discussion following the presentation of papers. He stated that ample time will be allotted for a question and answer period.

Dr. M. D. Reiter of Wheeling is president of the Society, and Dr. W. L. Neal of Huntington, vice president.

Our greatest glory is not in never falling but in rising every time we fall.—Confucius.

Drs. Bobbitt and Sleeth Honored By Public Health Association

Dr. Ray M. Bobbitt of Huntington and Dean Clark K. Sleeth of the West Virginia University School of Medicine were honored recently by the West Virginia Public Health Association for "outstanding meritorious

Ray M. Bobbitt, M. D.

Clark K. Sleeth, M. D.

achievement in the field of public health in West Virginia."

Doctor Bobbitt, chairman of the Cabell-Huntington Health Department, received the "Citizen's Award" and Doctor Sleeth the "Professional Award" at the 38th annual meeting of the Association at the Hotel Frederick in Huntington, June 6-8.

Dr. N. H. Dyer, State Director of Health, presented the awards at a banquet held in connection with the meeting.

In making the presentations, Doctor Dyer cited the efforts of Doctor Bobbitt in organizing the Cabell-Huntington Health Department, surveying and securing financing to meet the health needs of the community and working for an expansion of health services.

Describing Doctor Bobbitt's work in bringing about construction of the present Cabell-Huntington Health Center, the Director of Health noted that "even some of Doctor Bobbitt's personal funds went into the project."

Doctor Bobbitt has long been active in organized medicine and is a former President of the West Virginia State Medical Association.

Doctor Sleeth was cited for his devotion to public health and distinguished service at the University.

"In addition to his teaching duties and professional societies, he gave his precious time to act as clinician for the local health department's pediatric clinic for nine years and as a clinician at their other clinics for more than 15 years," Doctor Dyer said.

He added that Doctor Sleeth had served as part-time health officer in his local health department on two different occasions to sustain health services when the agency was without the services of a full-time physician.

The Association also presented a "Merit Award" to E. L. Peters of Charleston, director of the bureau of barbers and beauticians in the State Department of Health. The award was made for his work in rehabilitating patients who had lost their ability to speak because of cancer surgery.

Twenty-five year service awards were presented to Mrs. Minnie Board, an employee of the State Health Department in Charleston; Mrs. Mary Cummings of the Lewis County Health Department in Weston; and Mrs. Viola Loudermilk of the Greenbrier County Health Department in Lewisburg.

More than 200 persons attended this year's Conference. The theme for the meeting was "Reexamining Our Responsibilities in Today's World."

New Officers Named

Mrs. Wanda B. Johnson of Charleston, a member of the staff of the Kanawha-Charleston Health Department, was installed as president during the three-day meeting. She succeeds Mrs. Eva B. Green of Huntington, a member of the staff of the Cabell-Huntington Health Department.

William H. Lively of Charleston, Executive Secretary of the West Virginia State Medical Association, was named president elect; and Calvin E. Beckelheimer of South Charleston and James C. Rosencrance of Charleston, were reelected vice president and treasurer, respectively.

Dr. Gerald R. Guine of Charleston, director of the State Department of Health's division of dental health, was elected a Member-at-Large to the Executive Council. Holdover members are Dr. N. Allen Dyer of Bluefield and Mr. Harry K. Gidley of South Charleston.

Dr. L. A. Dickerson of Charleston was named the Association's delegate to the American Public Health Association, and the alternate is Dr. Deane F. Brooke of Beckley.

The executive secretary of the organization is Mrs. Katherine L. Brown of Charleston.

Annual Rural Health Conference At Jackson's Mill, Oct. 4

The 15th annual Rural Health Conference, sponsored by the West Virginia State Medical Association, will be held at the WVU Medical Center in Morgantown on Thursday, October 4, 1962.

The announcement was made by Dr. Martha J. Coyner of Harrisville, Chairman of the Association's Rural Health Committee. She said the theme for the one-day meeting will be "The Program at the WVU Medical Center and How It Benefits the Rural Areas of the State."

The program is being arranged by Doctor Coyner in consultation with officials at the Medical Center, and one of the features of the meeting will be a guided tour of the Basic Sciences Building and Hospital.

Further information concerning the program will appear in future issues of *The Journal.*

Diagnostic and Treatment Services For Cancer Again Curtailed

For the sixth consecutive year diagnostic and treatment services provided by the Division of Cancer Control of the State Department of Health were interrupted before the end of the fiscal period.

In a recent issue of the department's "State of the State's Health," it was announced that acceptance of new applications for aid was "sharply curtailed" as of June 1.

"Funds for the Cancer Control Program are used for reimbursement of physicians and hospitals for diagnosis and treatment of indigent and medically indigent patients," State Director of Health N. H. Dyer explained.

"It is impossible to say how many lives will be sacrificed needlessly this year because of our failure to provide adequate financial support for this vital program," he asserted.

Every Case an Emergency

He added that the self-defeating nature of the financial problem is obvious, since the purpose of the program is to encourage early detection and diagnosis while the disease is still in the stage where a cure can be effected.

"Every case of cancer is an emergency," he declared. "Unfortunately, the disease does not recognize fiscal consideration."

Eliminating 3,760 cases in which cancer was suspected and ruled out, the health director observed that the departmental register still lists 5,299 active cases or nearly 50 per cent of the number recorded since the program had its beginning in 1944.

He compared this record to data released by the National Health Education Committee which indicates that two-thirds of all cancer patients die from the disease.

"Certainly, no one can speak with final authority as to when a cure is effected in cancer patients," he said.

"On the other hand, it must be evident that our cancer control program is saving lives when the number of patients living exceeds whose who have died or in whom the disease is considered hopeless."

He praised the "splendid cooperation received from practicing physicians in the state who put patient welfare above all other considerations and have given service far beyond any financial reimbursement they received from this department."

Grant for Vitamins

Doctor Dyer also announced a grant of $15,231.60 from the U. S. Children's Bureau to be used to purchase vitamins for distribution to infants, young children, and expectant mothers whose main food source comes from surplus commodities.

He said that the grant provided funds to purchase 24,192 vials of ADC Vitamins for distribution to infants and young children and 1,800 bottles of prenatal vitamins for expectant mothers.

The vitamins will provide diet supplements for approximately three months, he explained, and will be available to needy families through local health departments.

B-R-T Postgraduate Session Held in Elkins

The 13th Annual Postgraduate Session of the Barbour-Randolph-Tucker Medical Society was held at the Elks Country Club in Elkins on June 21.

The following scientific program was presented during the one-day meeting:

"The County Medical Society's Role in Preventive Medicine, Especially Cancer Detection."—Mary DeWitt Pettit, M. D., Professor of Gynecology, Woman's Medical College of Pennsylvania.

"Obstructive Lesions of the GI Tract in Infancy."—Bertram R. Girdany, M. D., Professor of Radiology, University of Pittsburgh School of Medicine.

"Clinical Application of Recent Advances in Genetics."—Wayne H. Borges, M. D., Professor of Research, University of Pittsburgh School of Medicine.

"Traumatic Injuries of the Chest."—Herbert E. Warden, M. D., Associate Professor of Surgery, West Virginia University School of Medicine.

The guest speaker at the banquet was D. S. Heeschen, acting director of the National Radio Astronomy Observatory at Green Bank.

Dr. James S. Klumpp of Huntington, right, received this plaque as an "Ambassador of Good Will" at the recent annual meeting of the Ohio State Medical Association in Columbus. Also shown in the picture is Dr. Edwin H. Artman of Chillicothe, Ohio, a past president of the Ohio State Medical Association.

Heart Association Research Grants

West Virginians' contributions to the Heart Fund have helped make possible the award of $4,100,000 for research in the field of heart and blood vessel diseases.

Dr. Morris H. O'Dell of Charleston, president of the West Virginia Heart Association, said recently the awards are part of a $10,000,000 research effort being underwritten by the American Heart Association and its affiliates for the 1962-63 fiscal year.

Emphasizing the urgency of this program, Doctor O'Dell pointed out that 920,000 Americans, including nearly 10,000 West Virginians, died of these diseases in 1960. He said this is considerably higher than the 602,000 American lives lost in all the wars in which our nation has fought.

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected since January 1, 1962:

Barbour-Randolph-Tucker

Gow, Robert C. — Elkins
Shinkawa, Shigeo — "

Boone

Cooley, William S. — Wharton

Cabell

Hoffman, Charles A., Jr. — Huntington
Hernandez, Leopoldo — West Hamlin
Konieczny, Leo S. — Huntington
Korstanje, Marion C., Jr. — "
McKee, Thomas Craig — "
Whittaker, William B. — Barboursville
Williams, David H. — Huntington

Eastern Panhandle

Jarsen, Frank J. — Charles Town

Harrison

Hall, Phillip W. — Clarksburg
Harron, Ray A. — Bridgeport
Kucewicz, William J. — "

Kanawha

Browning, Richard James — Charleston
Lambrechts, Marcel G. — "
Nelson, James Henry, Jr. — "
Selinger, Harold — "
Velasquez, Benjamin G. — South Charleston
Withrow, Curtis L. — Charleston

Logan

Glenn, Donald L. — Man

McDowell

Berry, William J. — Welch

Mercer

Stovall, Richard Lee — Princeton

Monongalia

Andrews, Charles E. — Morgantown
Bloor, Byron M. — "
Conn, Rex B. — "
Flink, Edmund B. — "
Fugo, N. W. — "
Jones, Barbara — "
Klingberg, William G. — "
Moran, Walter H., Jr. — "
Warden, Herbert E. — "
Wiley, James Hugh — "
Zimmermann, Bernard — "

Ohio

Dye, Robert A. — Wheeling
Hofreuter, Donald H. — "
Smith, David H. — "
Voss, E. C., Jr. — "
Ward, Stephen D. — "

Parkersburg Academy

Cobern Charles B. — Parkersburg
Hughes, Francis H., Jr. — "
Morales, Alfonso — "

Potomac Valley

Moomau, Frederick — Petersburg
Rogers, Clinton L. — Sheppard Air Force Base, Witchita Falls, Texas

Preston

Ruegsegger, Franklin M. — Oakland, Md.

Raleigh

Daniel, John M. — Beckley
English, John W. — "
Flowers, Nancy C. — "
Judd, Allyn Francis — "

Dr. Byron W. Steele Named W. Va. 'GP of the Year'

Dr. Byron W. Steele of Mullens is West Virginia's "General Practitioner of the Year" for 1962. The selection was made by the Council of the West Virginia State Medical Association from a field of nominees submitted by component societies. Final action was taken by the Council at the summer meeting in Charleston on May 20.

Byron W. Steele, M. D.

Doctor Steele, who will be 73 years of age on July 14, was born at Moundsville in 1889. He attended public schools in Moundsville and was graduated from Marshall College in 1910. He received his M.D. degree from the University of Maryland School of Medicine in 1914.

Doctor Steele served as an instructor at the University of Maryland School of Medicine for a year and was on the staffs of two hospitals in Baltimore before he located at Mullens in 1916.

He practiced in Mullens until receiving a commission as First Lieutenant in the Medical Corps of the United States Army in 1918. He served as a surgeon at base hospitals overseas and was released with the rank of Captain in 1919, and returned to his practice at Mullens.

Doctor Steele is a member of the Wyoming County Medical Society, the West Virginia State Medical Association and the American Medical Association. In addition to his private practice, he is a staff member of the Wyoming General Hospital in Mullens and has served as physician for the railroad since 1923.

He married the former Frances P. Ould of Glenlyn, Virginia, in 1920, and they have two sons, one of whom is a physician.

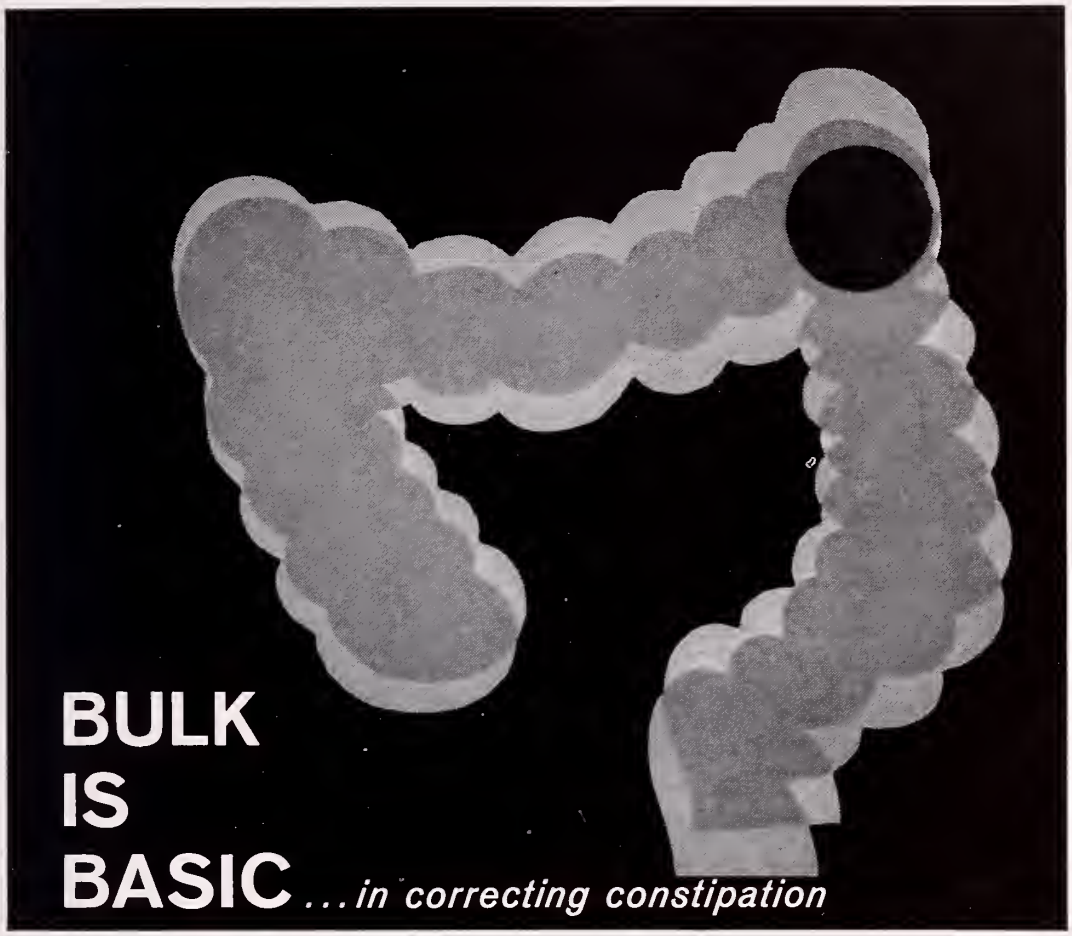
Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston 24, West Virginia.

Health Insurance Benefits

The Health Insurance Institute reported recently that health insurance benefit payments by insurance companies during the first three months of 1962 totaled $947 million.

The Institute said insurance companies paid this amount in health insurance benefits to the public through the end of March, and said the sum was 10.9 per cent higher than the $854 million distributed in the first three months of 1961.



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Metamucil is available as Metamucil powder in 4, 8 and 16-oz. containers and as lemon-flavored Instant Mix Metamucil in cartons of 16 and 30 single-dose packets.

1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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Research in the Service of Medicine

WVU Medical Center
—News—

THE first recipient of a scholarship awarded annually by the West Virginia State Medical Association to a student enrolled in the West Virginia University School of Medicine was among the fifteen students who received their M. D. degrees at commencement exercises in Morgantown on June 4.

Dr. Larry Hemmings of St. Marys, formerly of Charleston, received the scholarship at the beginning of his four-year training in 1958. The four-year scholarship was worth $4,000.

He will serve his internship at the United States Naval Hospital in Bethesda, Maryland.

Doctor Hemmings attended public schools in Charleston, where he was an outstanding student and athlete at Stonewall Jackson High School. He was graduated in 1958 from Virginia Polytechnic Institute.

He is married and the father of one child. His wife attended the WVU School of Nursing and she plans to complete her training in Baltimore.

Dr. Larry Hemmings of St. Marys, right, receives congratulations from Dr. D. E. Greenlitch of Wheeling, President of the West Virginia State Medical Association, as the first recipient of an Association scholarship to receive an M. D. degree from the West Virginia University School of Medicine. Doctor Hemmings was awarded the scholarship at the beginning of his four-year training in 1958.

• **Compiled from moteriol furnished by Cletis Pride, Public Informotion Officer, West Virginia University Medical Center, Morgontown, W. Va.**

Note of Appreciation

The following note of appreciation, addressed to the Executive Secretary, was received from Doctor Hemmings:

Morgantown, W. Va.
June 10, 1962

Mr. William H. Lively, Executive Secretary
West Virginia State Medical Association
Box 1031
Charleston 24, West Virginia

My dear Mr. Lively:

Four years ago the road to a medical education seemed long and difficult for me, but with the scholarship the Association granted me, some industry on my part, and the help of friends and family we have been fortunate enough to complete four years of training and to have been granted our degree.

I feel that I should send to you and all the members of the Committee and the Association this note of thanks until the time when I shall be able to pay back my debt to you all in the terms set forth in our contract.

As I go into internship and military service, I look forward to the time when I shall return to practice in West Virginia and hope that I may be of some help to those who have done so much for me.

Sincerely,
(Signed) Larry Hemmings, M. D.

The Association now awards two scholarships annually to students enrolled in the first-year class at the School of Medicine.

Administrative Assistant Named

Howard L. Lewis of Charleston has been named administrative assistant to Dr. Kenneth E. Penrod, Vice President—University Medical Center.

Mr. Lewis, who was a member of the staff of the Charleston Daily Mail for the past two years, assumed his new duties at the University on June 11. He will serve as an information officer and publications advisor for the four schools and hospital which comprises the Medical Center.

A native of Madison, Mr. Lewis served as editor-in-chief of the Daily Athenaeum, student newspaper, as a WVU undergraduate. He received his B. S. degree in journalism there in 1959 and his master's degree in political science the following year.

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FORMULA: *Each 15 ml. (tablespoon) contains:*

Sulfaguanidine U.S.P.	2 Gm.
Pectin N.F.	225 mg.
Kaolin	3 Gm.
Opium tincture U.S.P.	0.08 ml.

(equivalent to 2 ml. paregoric)

Warning: May be habit forming.

DOSAGE: **Adults**—Initially 1 or 2 tablespoons from four to six times daily, or 1 or 2 teaspoons after each loose bowel movement; reduce dosage as diarrhea subsides.

Children—½ teaspoon (= 2.5 ml.) per 15 pounds of body weight every four hours day and night until stools are reduced to five daily, then every eight hours for three days.

SUPPLIED: *Bottles of 1 pint (raspberry flavor, pink color)*
Exempt Narcotic. Available on Prescription Only.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association challenged the Kennedy Administration on the accuracy and legality of its propaganda campaign for the King-Anderson bill. Dr. F. J. L. Blasingame, executive vice president of the AMA, wired Attorney General Robert Kennedy about a booklet issued by the Department of Health, Education and Welfare. Dr. Blasingame said:

"This booklet lobbies for the enactment of the King-Anderson bill. This bill would raise social security taxes to provide limited health services to aged beneficiaries, regardless of whether they need financial help.

"The Department of Health, Education and Welfare has used tax funds, collected from everyone, to propagandize for a bill which many people and many groups have vigorously opposed. Under law, the publishing of this kind of a booklet without Congressional authority is a criminal act, punishable by fine or imprisonment, or both, and removal from office."

Dr. Leonard W. Larson, AMA President, wrote President Kennedy correcting a misstatement the Chief Executive made at a news conference. The President told his news conference that "the AMA was one of the chief opponents of the Social Security system in the 30's."

Doctor Larson pointed out to Mr. Kennedy that the American Medical Association had never opposed the Social Security system, either before or after its adoption.

"The Association," Doctor Larson's letter said, "testified before Congress on only one section of the Social Security legislation, the section concerning extension of public health services. It should be noted that the AMA testified in support of this section."

'Taxpayers' Money for Lobbying Purposes'

Doctor Blasingame also called on the Justice Department to stop Cabinet members using taxpayers' money for lobbying purposes and to launch an investigation of "improper" lobbying activities of employees of the Department of HEW.

Doctor Blasingame in a letter to Attorney General Robert Kennedy listed more than a dozen incidents which he said violated federal statutes prohibiting lobbying by federal employees and officials.

"Government employees," Doctor Blasingame said, "are being sent out as speakers, at public meetings to urge enactment of the Administration's bill. This, in our opinion, is a clear violation of Title 18, Section 1913 of the U.S. Code on crimes and criminal procedure which prohibits among other things the use of 'personal services' for lobbying purposes."

Doctor Blasingame said that Secretary of Commerce Luther Hodges, Secretary of Labor Arthur Goldberg and Interior Secretary Stewart Udall were appearing at rallies concurrent with President Kennedy's appearance in Madison Square Garden in the Administration's campaign for the King-Anderson bill.

"We strongly protest the use of tax monies by these Cabinet members to lobby for a bill which is clearly not within the scope of their respective departments," Doctor Blasingame said. "I call on you to issue an injunction against this type of activity by these Cabinet members."

The AMA Executive Vice President also noted that between six and ten government employees "have been lobbying in the White House offices for several months" for the King-Anderson bill. He said the group occupying a four-room suite "has been writing television and radio scripts, drafting advertisements and helping with publicity releases for various organizations which are backing the King-Anderson bill."

Honest Accounting Demanded

Doctor Larson also urged that "the American people demand an honest accounting from the Department of Health, Education and Welfare on how much of their tax money the department is spending for lobbying for the King-Anderson bill."

"The people have a right to know how much of their tax money this federal agency is spending in lobbying for this piece of legislation," Doctor Larson said in a speech before the Academy of Medicine of Cincinnati. He also said that the National Council of Senior Citizens should be required to register as a lobbyist.

"This organization was founded by former Congressman Aime Forand for the express purpose of lobbying for passage of the King-Anderson bill," Doctor Larson said.

In a statement, Doctor Larson cited contradictory statements by two prominent advocates of President Kennedy's health-care-for-the-aged bill—Ribicoff and Rep. Cecil R. King (D., Calif.).

"Mr. Ribicoff and Mr. King may be on the same team but they are in basic disagreement as to the extent of services social security should provide, and how much of an increase in taxes the public will tolerate to finance these services," Doctor Larson said.

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Iron *(Ferrous Betaine Citrate)*	30 mg.
Cobalt *(Cobalt Betaine Citrate)*	0.1 mg.
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5 B-COMPLEX VITAMINS

Vitamin B_1	1.5 mg.
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County Societies

BARBOUR-RANDOLPH-TUCKER

Dr. R. W. Cronlund of Philippi was elected president of the Barbour-Randolph-Tucker County Medical Society at the regular monthly meeting held on May 17 at the Blackwater Lodge near Davis.

Other officers named for the coming year are as follows: Dr. H. L. Jellinek of Elkins, first vice president; Dr. Semon M. Lilienfeld of Parsons, second vice president; Dr. A. Kyle Bush of Philippi, secretary; and Dr. Guy H. Michael, Jr., of Parsons, treasurer.

Drs. G. E. Hartle of Moorefield and Charles L. Leonard of Elkins were named delegates to the annual meeting of the West Virginia State Medical Association at The Greenbrier in August. Drs. Cora C. Lenox of Philippi and Homer D. Martin of Dailey were named alternates.

Dr. John W. Nelson, head of the Department of Neurology at the West Virginia University School of Medicine, presented an interesting paper on "Convulsions Beginning in Adult Life."

During the business meeting, Dr. Shigeo Shinkawa of Elkins was elected to membership in the Society.—A. Kyle Bush, M. D., Secretary.

CABELL

Dr. Merle S. Scherr of Charleston was the guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on May 10.

Doctor Scherr, an allergist, presented an interesting paper on "Repository Emulsion Therapy in Immunology and Allergy."

Dr. C. A. Hoffman discussed the National Blue Shield's Senior Citizen Program. The Society approved the program in principle.

The members of the Society observed a moment of silence in memory of Dr. Melvin W. McGehee of Huntington, who died on April 11.

The application of Dr. Bascomb B. Young of Huntington for transfer of membership from the Kanawha Medical Society was approved.

Drs. C. Stafford Clay, D. Sheffer Clark and W. L. Neal, all of Huntington, and W. D. Bourn of Barboursville, were named delegates to the annual meeting of the West Virginia State Medical Association at The Greenbrier in August. Named alternates were Drs. Roy A. Edwards, Jr., Sarah Louise Stevens, James A. Heckman and M. L. Hobbs.

Doctor Heckman read a detailed report from the recently appointed Lawyers-Doctors Committee, which contained suggestions for a closer working relationship between members of the professions.—W. L. Neal, M. D., Secretary.

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If you are now prescribing the newer corticosteroids— such as triamcinolone, betamethasone, paramethasone or another brand of dexamethasone, because of reduced risk of sodium and fluid retention, potassium depletion, or disturbance of glucose metabolism—you can obtain all of these benefits with HEXADROL, at marked savings—yet with complete assurance of unsurpassed quality and therapeutic effect.

For complete information concerning HEXADROL— including indications, dosage, precautions and side effects—or if you would like a trial supply, ask your Organon Representative, or write to: Director, Professional Services, Organon Inc., West Orange, N. J.

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KANAWHA

Dr. George H. Vick of Atlanta, Georgia, was the guest speaker at the regular monthly meeting of the Kanawha Medical Society which was held at the Daniel Boone Hotel in Charleston on June 12.

Doctor Vick, former pastor of the First Presbyterian Church in Charleston, and now executive secretary of the Presbyterian Board of Annuities and Relief, delivered an inspiring address on the manner in which individual freedom would be affected by legislation now pending in Congress.

Dr. Robert C. Bock, the president, presided at the business session and Drs. V. J. Dorset and Andrew W. Goodwin were unanimously accepted to membership in the Society.

The Society instructed its delegates to the annual meeting of the State Medical Association to submit once again a resolution endorsing enactment of a medical examiner's bill in West Virginia.

The following physicians were elected as delegates to the state meeting:

Drs. George R. Callender, Jr., Carrel M. Caudill, Arthur C. Chandler, Donald R. Gilbert and James H. Getzen, Charleston; Ralph J. Holloway, South Charleston; Milton J. Lilly, Charleston; James S. Kessel, Ripley; and Richard N. O'Dell, William B. Rossman, Robert C. Bock, Ralph H. Nestmann and Alfred J. Magee, Charleston.

Alternates named were Drs. Spencer L. Bivens and Marshall J. Carper, Charleston; William D. Crigger, South Charleston; R. O. Dawson, George V. Hamrick, James W. Lane, Arthur K. Lampton, George H. Pierson, Jr., Thomas G. Potterfield, Grover B. Swoyer and W. A. Thornhill, Jr., Charleston; Richard C. Wallace, St. Albans; and John G. Zekan, Charleston.

* * * *

MARION

Dr. Claude S. Lawson, Jr., of Fairmont, was elected president of the Marion County Medical Society at its May meeting at the Fairmont Hotel in Fairmont.

Other new officers for the coming year are as follows: Dr. James E. Wotring of Fairview, vice president; Dr. G. Thomas Evans of Fairmont, secretary; and Dr. David Bressler of Fairmont, treasurer.

Drs. John J. Coogle, William A. Ehrgott, William T. Lawson and retiring president F. W. Mallamo, all of Fairmont, were named to the board of directors.

* * * *

MERCER

Dr. Samuel M. Fox of Washington, D. C., was the guest speaker at the regular monthly meeting of the Mercer County Medical Society which was held at the University Club in Bluefield on May 21.

Doctor Fox, the medical monitor of cardiographics for the space flight of Lt. Col. John Glenn, discussed "Research and Findings in Heart Disease." During the orbital flight, he was stationed at the Zanzibar tracking station in East Africa and maintained voice contact with Colonel Glenn.

Dr. Joe E. McCary of Princeton, the president, intro-

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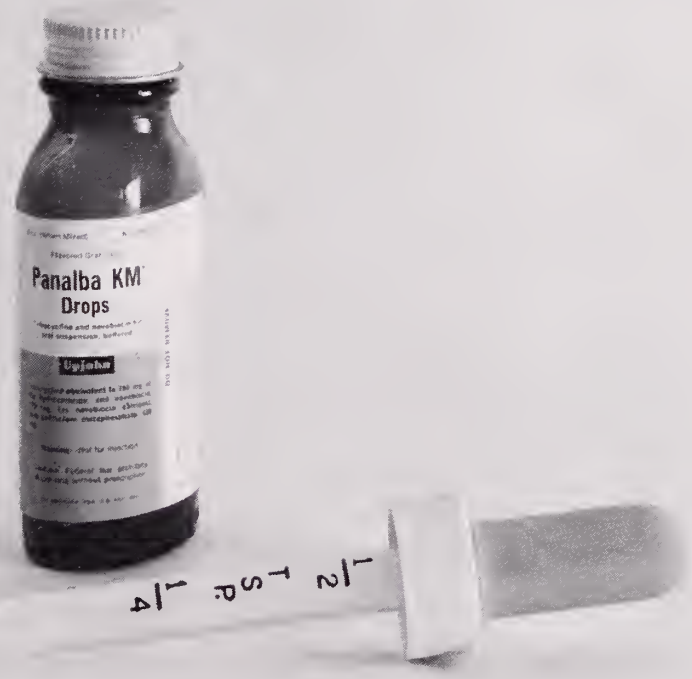

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Panalba combines tetracycline (selected for its breadth of coverage) and novobiocin (selected for its unique effectiveness against staph). That is why, in most bacterial infections of unknown etiology, Panalba offers excellent chances for therapeutic success—and why it should be your antibiotic of *first* resort.

Supplied: Flavored granules for suspension, in 30 cc. bottles with dropper-stopper calibrated in ¼ and ½ teaspoonful graduations. After mixing and shaking with 25 cc. water, each 5 cc. teaspoonful of suspension will contain:

Panmycin* (tetracycline) equivalent to tetracycline hydrochloride .... 125 mg.
Albamycin* (as novobiocin calcium) ..... 62.5 mg.
Potassium metaphosphate ... 100 mg.

Usual pediatric dosage: ½ teaspoonful per 7½ to 10 pounds of body weight per day, administered in two to four equally divided doses.

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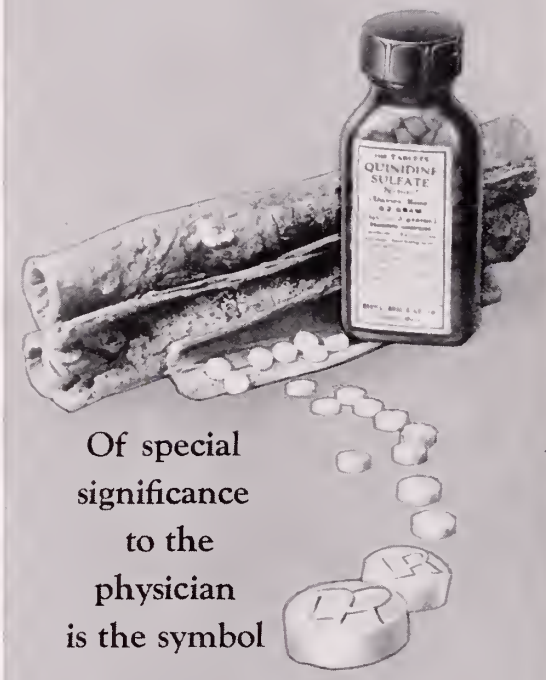

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When the physician writes "DR" (Davies, Rose) on his prescriptions for Tablets Quinidine Sulfate, he is assured that this "quality" tablet is dispensed to his patient.

Rx Tablets Quinidine Sulfate Natural
0.2 Gram (or 3 grains)
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Clinical samples sent to physicians on request

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Q-7

duced as guests Miss Edith Youngblood and Miss Dorothy Rogers, both of Washington, D. C. Miss Youngblood is a hypertensive heart study statistician and Miss Rogers a public health analyst.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. D. E. Greeneltch of Wheeling, President of the West Virginia State Medical Association, spoke at the regular monthly meeting of the Monongalia County Medical Society which was held at the Hotel Morgan in Morgantown on May 1.

The meeting was open to the public and more than 200 persons heard Doctor Greeneltch discuss the present MAA program in West Virginia and the proposed King-Anderson legislation. A question and answer period followed his address.

A dinner meeting preceded the open meeting with more than 80 persons in attendance.—George A. Curry, M. D., Secretary.

Fraud in the King-Anderson Bill

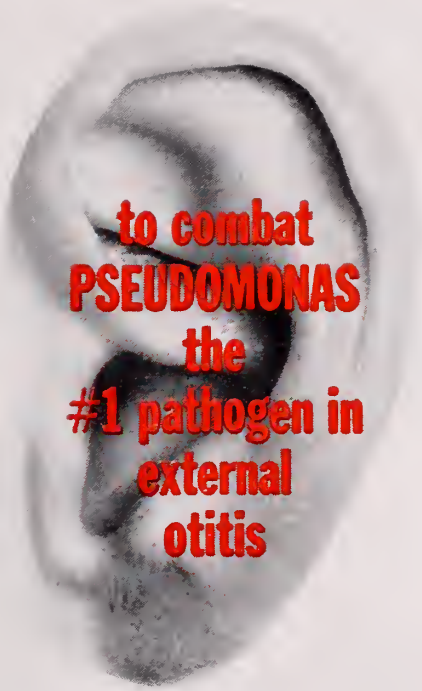
In one of its most important aspects, the President's "all-or-nothing" medical care program boils down to this: Why should a young men, working hard to support himself and his family and provide for medical care, assume the further burden of providing medical care for 17 million "senior citizens," many of whom don't need, don't want and are not asking for this assistance?

That is a fairly complicated question, but it embraces a simple fact. Under the President's and the AFL-CIO's compulsory "medicare" plan, the full cost of this assistance to 17 million aged would be loaded upon their children. The tax base for their Social Security deductions will go at once from $4,800 to $5,200, and they will pay the price for the rest of their working lives.

Supposing they are inspired by humane motives to help the helpless and care for the sick, there is no injustice in this and, indeed, a considerable charity. But this is not the choice afforded them. On the President's terms, if they are disposed to help the needy, they must help the needless as well. They must help the poor man who needs hospitalization. They must also help the richest man in the United States who is perfectly capable of meeting his own medical costs.

This is the great fraud in the King-Anderson bill. We are asked to believe on faith and apart from all fact (1) that all Americans upon reaching the age of 65 pass at once into a state of senility, poverty and dependence and (2) that there is no remedy for their condition save a program which taxes everyone else indiscriminately and forever after.

Even the political appeal of this scheme, we suspect, is greatly exaggerated, judging from the attendance at the rallies set up to generate public enthusiasm. And it would be even less if the great majority of working Americans understood fully the size of the burden they are being asked to assume.—Charleston Daily Mail.



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- Anti-inflammatory
- Antipruritic
- Antibacterial

Each cc. contains:
'Aerosporin'® brand Polymyxin B sulfate ..... 10,000 units
Neomycin Sulfate ..... 5 mg.
(Equivalent to 3.5 mg. Neomycin Base)
Hydrocortisone ..... 10 mg. (1%)

Bottles of 5 cc. with sterile dropper.

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HUNTINGTON, WEST VIRGINIA

Woman's Auxiliary

to the

WEST VIRGINIA STATE MEDICAL ASSOCIATION

President: Mrs. Vernon L. Dyer, Petersburg
President Elect: Mrs. Howard G. Weiler, Wheeling
First Vice President: Mrs. John W. Hash, Charleston
Second Vice President: Mrs. L. Dale Simmons, Clarksburg
Third Vice President: Mrs. Earl S. Phillips, Wheeling
Fourth Vice President: Mrs. Lee F. Dodds, Huntington
Treasurer: Mrs. Andrew J. Weaver, Clarksburg
Recording Secretary: Mrs. J. A. B. Holt, Charleston
Corresponding Secretary: Mrs. Fred Moomau, Petersburg
Parliamentarian: Mrs. D. E. Greenleich, Wheeling

FAYETTE

Mrs. Joe N. Jarrett of Oak Hill was installed as president of the Woman's Auxiliary to the Fayette County Medical Society during the May meeting which was held at the Glenn Farris Inn in Falls View.

Other new officers installed were: Mrs. E. E. Jones, Jr., of Mt. Hope, president elect; and Mrs. J. B. Thompson of Oak Hill, treasurer.

Mrs. John W. Hash of Charleston, first vice president of the Woman's Auxiliary to the West Virginia State Medical Association, installed the new officers and also delivered an interesting address on the proposed King-Anderson legislation.

Radiology:
KARL J. MYERS, M. D.

Clinical Pathology:
E. E. MYERS, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Anatomic Pathology:
S. D. WU, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

Resident Staff:
ORAL E. BARKAY, M. D.
LEOPOLDO I. PENA, M. D.
TADAO NAGASHIMA, M. D.

THE MYERS CLINIC
Philippi, West Virginia

It also was announced that the group had contributed $100 to the American Medical Association Education and Research Foundation to be applied to the West Virginia University School of Medicine.

* * * *

GREENBRIER VALLEY

Mrs. Vernon L. Dyer of Petersburg, president of the Woman's Auxiliary to the West Virginia State Medical Association, was the guest speaker at the May meeting of the Woman's Auxiliary to the Greenbrier Valley Medical Society which was held at the home of Dr. and Mrs. Robert R. Pittman in Marlinton.

Mrs. Dyer was accompanied by Mrs. Lysle T. Veach, of Petersburg, convention chairman for the Auxiliary's 38th annual meeting at The Greenbrier in White Sulphur Springs, August 23-25.

* * * *

PARKERSBURG ACADEMY

Mrs. Lawrence R. Leeson was installed as president of the Woman's Auxiliary to the Parkersburg Academy of Medicine during a luncheon meeting which was held at the Chancellor Hotel in Parkersburg on May 8.

Mrs. Lee F. Dodds of Huntington, fourth vice president of the Woman's Auxiliary to the West Virginia State Medical Association, was the installing officer.

Other new officers for the coming year are as follows: Mrs. Charles W. Thacker, president elect; Mrs. Rex Dauphin, vice president; Mrs. R. C. Cowan, Jr.,

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second vice president; Mrs. George W. West, recording secretary; Mrs. Richard J. Lilly, corresponding secretary; Mrs. Watson F. Rogers, treasurer; and Mesdames Charles H. Barnett and George Gevas, elective board.

Mrs. Gevas, the retiring president, was presented a sterling silver bowl in appreciation for her service during the past year.

Need a Physician?

Communities in rural areas in West Virginia that are interested in securing a physician may have their requests published in the classified section of *The West Virginia Medical Journal*. Interested persons should submit the population of the area in which the physician is needed and send along a descriptive sentence of their requirements and advantages of practice.

Such information will be published in *The Journal* in the hope that physicians in the state may have medical colleagues who might be interested in the practice of rural medicine in West Virginia.

A listing of physicians wishing to locate in West Virginia will also be published, provided they submit their qualifications to the headquarters offices of the State Medical Association. This service will be provided to communities and physicians without charge.

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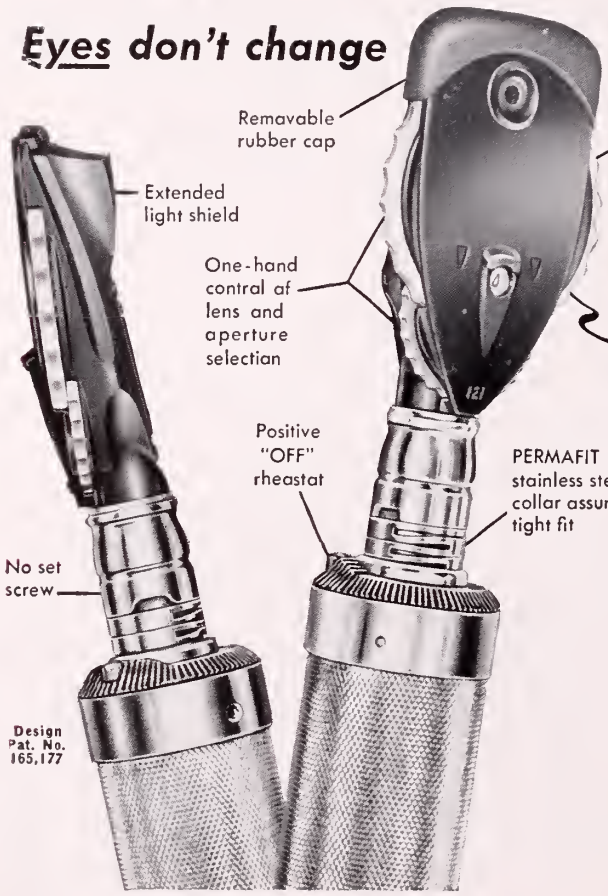

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Book Reviews

MEDICAL STATE BOARD QUESTIONS AND ANSWERS—By Harrison F. Flippin, M. D., Clinical Professor of Medicine, Graduate School of Medicine, University of Pennsylvania. Pp. 507. W. B. Saunders Company: Philadelphia and London. 1962. Tenth Edition. Price $9.50.

This book is now in its tenth edition which must be proof of its place in medical education.

It will be a great help to medical students and physicians who are writing state board medical licensing examinations. If the 480 pages of its contents are thoroughly understood, it will carry the examinee through almost any type of essay examination. It covers all the fields of basic science and clinical medicine.

Any reviewer will disagree with some of the succinct answers to various questions, for instance on page 237, the question is asked, "Name the three basic principles of tuberculosis therapy in order of importance," and the author gives: (1) systemic; adequate nutrition and limitation of physical activity, (2) surgical correction of certain mechanical factors which prevent adequate control of the disease, and (3) antituberculous agents. Certainly this contributor belonged to the horse and buggy days.

The book will provide a good review for the critical graduate. It will be most helpful to the oldster who faces an examination of his medical knowledge. It is also helpful to the official who finds it necessary to prepare licensing examinations.

The constant revision of this manual assures its value to all students and doctors who require a complete, brief and precise review of basic and clinical medicine.—George F. Evans, M. D.

* * * *

THE SCIENCE OF DREAMS—By Edwin Diamond, General Editor, Newsweek. Pages 264. Doubleday & Company, Inc., Garden City, New York, 1962. Price $4.50.

This book is a composite study of many areas of dream research written by a lay science editor who became quite interested and intrigued by this very fascinating subject, and set forth to collect data about it. In the preface to the volume, the author's list of resources of persons runs from Doctor Kleitman in California, through Doctor Penfield to Aldous Huxley and many other famous names, both in the fields of science and the humanities. The most often quoted men in the review are Drs. Dement, Fisher, Kleitman, Wolpert and Shapiro.

In the book itself there is a rather logical sequence of ideas developed by the author, beginning with the historical aspect of dreams and their interest to ancient man. This is continued down through the years to include the work of Freud. Also, the many observations made on the Iroquois Indians and their usages and understanding of dreams are mentioned. After the work of Freud, the author then draws upon many of the modern day research projects which deal with efforts

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to understand, code, and interpret dreams in people whose mental states are both healthy and sick.

References are made to the tachistoscope experiments of Fisher and the subliminal slides, also used by Fisher in his dream research work. Then, there is reference material from the Kinsey reports and efforts to find a single dream that might represent a "dream of a culture." Following this bit of research data, the author brings in the extensive use of the electroencephalograph and the correlation between electroencephalographic tracings, rapid eye movements, and the reporting of dreams by experimental subjects.

Other speculations in the area of dream science are made in the attempt to explain the forgetting of dreams and dreams representing a storehouse of memories. Along with this, the need to dream is developed and compared with experiments that have been done in the fields of sensory deprivation and sleep deprivation. Dream screens, originally mentioned by Freud, have also been extensively explored by the author, basing his writings on the available research data that is now present.

Reading this book enables the physician to have at his command a great deal of research data that would otherwise be widely separated and unorganized. The author makes no claims for his own scientific knowledge regarding the science of dreams but does an excellent job of collecting and reporting in accurate detail the tremendous amount of research work that has been done. This book is simply written and is understandable in every respect. It contains some philosophical excursions but these add flavor, mainly, to the entire contents of the volume.

Since so much about dreams is not known to the average physician and is so rarely used by him, perusal of this book would provide an interesting stimulus and would open many vistas of new ideas regarding the place that dreams can play in the understanding of patients. For these and many other reasons, this book can be highly recommended to the physician as an addition to his current library.—William B. Rossman, M. D.

Books Received

A STUDY OF PSYCHOPHYSICAL METHODS FOR RELIEF OF CHILDBIRTH PAIN—By C. Lee Buxton, M. D., Department of Obstetrics and Gynecology, Yale University School of Medicine. Pp. 116. W. B. Saunders Company: Philadelphia and London. 1962. Price. $4.75.

* * * *

TREATMENT OF INJURIES TO ATHLETES—By Don H. O'Donoghue, M. D., Professor of Orthopedic Surgery, University of Oklahoma Medical School, Oklahoma City. Pp. 649, with numerous illustrations. W. B. Saunders Company: Philadelphia and London. 1962. Price $18.50.

* * * *

CURRENT THERAPY-1962—Edited by Howard F. Conn, M. D. Pp. 790. Philadelphia and London: W. B. Saunders Company, West Washington Square, Philadelphia, Pennsylvania. 1962. Price $12.50.

* * * *

DR. MARY WALKER: THE LITTLE LADY IN PANTS—By Charles McCool Snyder. Pp. 166, with pictures. Vantage Press, Inc., 120 West 97st Street, New York, New York. 1962. Price $3.95.

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Correspondence

WEST VIRGINIA UNIVERSITY
Morgantown

May 9, 1962

Mr. William H. Lively
Executive Secretary
West Virginia State Medical Association
401 Atlas Building
Charleston, West Virginia

Dear Mr. Lively:

On behalf of the Board of Governors of West Virginia University, I should like to express appreciation for your check in the amount of $14,374.64 which has been forwarded to me by Dean Clark K. Sleeth. The very generous grant is adequate evidence of the continued interest of your organization in our medical education and research programs and we are grateful for it. It was especially pleasing to learn that many of the contributions which went together to make up the grant were made by practicing physicians and members of their families. The sincere interest and support of old friends will always be a source of encouragement to those who are striving to build an outstanding medical education program at West Virginia University.

Sincerely yours,

(Signed) Paul A. Miller, President

* * * *

DEPARTMENT OF PUBLIC SAFETY
(West Virginia State Police)
Charleston

May 21, 1962
"Centennial '63"

Dr. L. J. Pace, President-Elect
W. Va. Medical Association
1330 Mercer Street
Princeton, West Virginia

Dear Dr. Pace:

West Virginia has again joined with all other states, territories, and Canadian Provinces in the promotion of the annual *Slow Down and Live Traffic Safety Program.* This program is sponsored by the Association of State and Provincial Safety Coordinators and has promoted safe summer driving for the last ten years. *Slow Down and Live* is the largest traffic safety program in the world.

The safety messages contained in this year's program may make an impression on some of our motorists. If they reach just one they are worthwhile. In order to have an impact at all, they need to be heard—they must be seen—they have to be read.

It is imperative that we make this program a success this year. You will recall that during the months of this program last year our traffic fatalities were substantially under the ten year average. In order that we compare favorably this year it is necessary that we have a well coordinated, comprehensive, and vigorous public safety education program.

I am writing to you in your capacity as President-Elect of the West Virginia Medical Association to request that you urge your members to give all possible assistance to this program for the period of Memorial Day through Labor Day.

You and the members of your organization can obtain full information regarding this program in our State by contacting your local State Police Detachment.

Sincerely,

(Signed) W. E. Burchett,
Superintendent

Mail Order Prescriptions

As a physician, what would your reaction be if a handful of doctors advertised medical care for patients by mail at "discount" prices? How effective would such "long distance" medical care be from the standpoint of *the patient's health?* This question is the core of a similar problem, that of mail order prescriptions.

Aside from the ethical principles involved, mail order prescriptions give rise to many problems, and physicians can decide whether they are in the best interest of the patient. Here are just a few examples of these problems:

To promote drug sales, mail order operators publish long lists of drugs, including many which are available to the public only on prescription. Such potent drugs, obviously, require close medical supervision. Yet, each day, mail order promoters fill such prescriptions written by physicians they do not know for customers they do not see.

Mail order prescription operators cannot readily determine whether a particular prescription was actually written by a physician or whether the prescription blank had been forged or stolen. Mail order prescriptions, therefore, may constitute a convenient way of obtaining drugs for illicit traffic.

It is costly and inconvenient for a mail order employee to phone a physician located a thousand miles away to determine whether a prescription refill was actually authorized by the doctor, to double-check the identity or strength of an ingredient, or to ask the physician some pertinent question.

Use of the mails also involves the danger of delays and the possibility of breakage, causing still further delay. Such delays tend to encourage self-medication. Moreover, they postpone the start or continuation of therapy which the patient may urgently need.

Prescription files for mail order prescriptions are not easily accessible. This can be dangerous if information is quickly needed as to which drug a patient is taking. On the other hand, prescription files, as well as the pharmacist himself, are readily accessible when prescriptions are filled at local pharmacies.

The above examples indicate the potential hazards of mail order prescriptions to the patient and to the physician. There is no substitute for the close physician-patient-pharmacist relationship, which operates for the benefit of the patient.—Irving Rubin, in Maryland State Medical Journal.

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WANTED—Physician to serve as chief of outpatient clinic in a 200-bed general medical and surgical hospital affiliated with the WVU School of Medicine. Salary dependent on qualifications. Many fringe benefits. Apply to Hospital Director, VA Hospital, Clarksburg, West Virginia.

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WANTED—House physician for GP duty in general hospital (125 beds). No exchange students. Foreign graduates with immigrant visa and fluent English, $500 monthly and single maintenance. Write Kenneth N. Byrne, M. D., Superintendent, Emergency Hospital, Welch, West Virginia

WANTED—Resident for recently approved three-year training program in Obstetrics and Gynecology. 3,356 admissions per year, of which more than 1,000 are clinic admissions, 3,844 clinic visits in last year and 910 service deliveries. Contact Dr. Irvin S. Perry, Director of Medical Education, Charleston Memorial Hospital, Charleston, W. Va.

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WANTED—Male psychiatrist under 50 years of age. Board certified or Board eligible to head established private psychiatric clinic in city of 75,000. Graduate of American medical school. Salary: $18,000 to $20,000, depending upon qualifications and experience. Plus liberal fringe benefits. Incentive plan permits additional earnings of $5,000 annually. Write MWH, The West Virginia Medical Journal, Box 1031, Charleston 24, W. Va.

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AUGUST
1962

Vol. 58 No. 8

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 343-4607.

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The West Virginia Medical Journal

August, 1962 Vol. 58, No. 8

Experiences With Surgery of The Sympathetic Nervous System

(With Case Reports)

E. Lyle Gage, M. D.

Since the days when "humors" and "animal spirits" were leading terms in medical philosophy, the sympathetic nervous system has held the interest of physicians. Galen and even Vesalius represented the vagus and the ganglionated sympathetic trunk as the sixth pair of cranial nerves, but Estienne or Stephanus (1545) and Eustachio (1522) distinguished the sympathetic from the vagus nerves anatomically.

Willis (1664) was one of the first to introduce the idea of involuntary movement as separate from voluntary and, in 1732, J. B. Winslow, the Danish anatomist, gave the ganglionic chain the name, "Grand Sympathique." White and Smithwick[24] credit Alexander, of Liverpool, with being the first to operate on the sympathetic nervous system. Alexander (1889) performed cervical sympathectomy for epilepsy. Jonnesco (1896) tried the operation in a large series of epileptic cases, and Jaboulay, of Lyons, tried it for goiter. Because of the lack of success of these operations interest died out for a while. Then, Jonnesco, in 1920, following the brilliant reasoning of Francois Frank (1889), resected cervical and thoracic sympathetic nerves for angina pectoris and his success in relieving the pain was the beginning of modern techniques for this condition. The danger inherent in thus relieving anginal pain now has been recognized.[24]

To Professor Rene Leriche,[20] of France, we owe a debt of gratitude for his persistent emphasis on the effectiveness of sympathectomy in the relief of visceral and vascular pain and, together with Hunter and Royle, for demonstrating the effect of sympathectomy in increasing the blood flow to the extremities.[20, 24]

To Adson, Craig, Peet, Crile, Smithwick and Grimson we credit much of the study and experience which led to the use of sympathectomy for hypertension.[1, 2, 3, 10]

Submitted to the Publication Committee, April 9, 1962.

The Author

- **E. Lyle Gage, M. D., Head, Department of Neurosurgery, Bluefield Sanitarium, Bluefield, W. Va.**

Field of Sympathetic Surgery and Conditions Treated

Because of the persistence and zeal of these pioneers, we have today a field of sympathetic surgery which includes blocking, anesthetizing, sectioning or removal of practically all parts of the ganglionated chain and often parts of the attached peripheral nerves. Conditions which have been treated by surgery of the sympathetic system are numerous. Among them are Raynaud's disease, Buerger's disease, arteriosclerotic peripheral vascular disease, causalgia, erythromelalgia, trench foot, thrombophlebitis, arterial thrombosis and embolism, amputation stump pain, phantom limb, edema of the arm following breast amputation, hyperhidrosis of nervous origin, vessel spasm after injury and poliomyelitis, retarded growth of limbs, Sudeck's atrophy, megalocoly, early scleroderma, angina pectoris, herpes zoster, dysmenorrhea, retinitis pigmentosa, hypertension, cerebral vasospasm, cerebral

thrombosis, and even depressive mental states.[2, 3, 4, 5, 24] Some of these conditions such as megalocoly, scleroderma and retinitis pigmentosa have not responded to sympathectomy.

Like all ventures in therapy, each new procedure involving the sympathetic nervous system had proponents with excess enthusiasm as well as spectators who scoffed. Careful research and honest clinical trial gradually have screened successes from failures.

Herpes Zoster

Herpes zoster and intercostal neuralgia sometimes are puzzling from a diagnostic standpoint, as well as hard to treat.[6] To differentiate them (at the onset of pain) from appendicitis, peritonitis, renal disease and intrathoracic conditions often is difficult. It must be remembered that segmental pain and skin hyperesthesia are characteristic. A knowledge of dermatomes and peripheral nerve anatomy is a necessity in this diagnosis. Mapping the area of skin sensitivity with a small galvanic electrode sometimes is helpful, and therapeutic nerve block with novocain often relieves symptoms and signs. Unilaterality is the rule, but there are exceptions. When vesiculation appears, the diagnosis is clear.

A number of patients with herpes zoster have been treated by paravertebral novocain block (single or multiple) of the ganglia of the affected nerves, and from this experience it seems that a patient thus treated within forty-eight hours of the first vesiculation or within seventy-two hours of the onset of acute pain, will be relieved and the course of the illness interrupted. Unfortunately both patient and physician tend to procrastinate in the treatment of "shingles" until too late for best therapeutic effects.

Arterial Thrombosis and Embolism

Thrombosis or embolism of an artery of a limb has its own specific treatment but, as De Takats[22, 23] has stated, sympathetic block or sympathectomy should be used in all cases of arterial occlusion, preceding embolectomy and following arterial ligation. It has been our experience that an extremity with a seemingly bad prognosis sometimes can be partially or totally saved by repeated sympathetic block, and that when amputation does become necessary, previous repeated block or sympathectomy often will have lowered the level of the amputation site and improved the circulation of the stump tissue.

One patient treated in our clinic had a cold foot and leg to midcalf following embolism. With repeated sympathetic block, partial refrigeration, and hydrogalvanism to the foot and leg, he later showed gangrene only of two middle toes and the lateral skin of the great toe, with a small, superficial 2 cm. area on the sole of the foot. No anticoagulants were used in treating this patient. Of course, when the main artery of a limb is suddenly and completely occluded sympathectomy usually will not save that limb and we should not hold out the hope that it will to the patient or his family. In such instances direct vascular surgery must be carried out promptly, as indicated.

Thrombophlebitis—Acute and Chronic

Paravertebral sympathetic block with novocain, as treatment in cases of acute and chronic thrombophlebitis, and lumbar sympathectomy in selected cases, proved worthwhile before anticoagulants were in general use.

Case Report

V. L. M., aged 42 years, first had a swelling in the right leg, in 1943, diagnosed as acute thrombophlebitis. He recovered and was well until February 11, 1947, when he had a severe pain in the right leg after handling a load of stock feed.

When first seen on May 5, 1947, he was limping on the right leg; the saphenous vein and the muscles of the calf were tender and although the popliteal area of the leg seemed warmer, the right foot was nearly 2 degrees cooler than the left, and the circumference of the right leg 2 cm. greater than that of the left. The dorsalis pedis pulse was present but the oscillographic reading was only 25 per cent of that in the well leg. There was no fever.

Paravertebral novocain block of the right second and third lumbar ganglia caused a 3 degree increase in temperature of the sole of the foot. The patient noted marked subjective improvement, and the warming effect on the foot was still evident the following day. The paravertebral block was repeated three times at weekly intervals, after which the patient was comfortable and was allowed to be freely ambulatory. All pain ceased but the affected leg remained slightly larger than the opposite leg.

The patient was seen again on December 30, 1947, with the left foot cold and painful to a point approximately 4 inches above the ankle. He stated that the disturbance in the left foot had occurred after it was bruised between two piles of lumber. The diagnosis was vasospasm, traumatic.

Paravertebral block of the left second and third lumbar ganglia produced warming to

normal temperature, which effect remained although only 2 per cent novocain had been used.

This case illustrates not only the beneficial effect of paravertebral block in an exacerbation of chronic thrombophlebitis, but also the lability of the peripheral vascular tree and the consequent associated arterial spasm which sometimes is an important factor to be considered in the treatment of these patients. It seems likely that the effect of sympathetic block or sympathectomy may be both on arteries and veins, but in the case of the veins it has to do primarily with their nourishment and the improved circulation of the small arteries of their walls, as well as the surrounding tissues.

While both the second and third lumbar ganglia were anesthetized in the above case, it is likely that blocking the second only would be sufficient to produce the effect on the lower leg and foot. On the other hand anatomical variations are such that on occasion, injections as high as the 12th thoracic ganglion have been necessary.

Case Report

Mrs. G. W. B., aged 27 years, had been hospitalized repeatedly. The diagnoses were endometrial hyperplasia, menorrhagia and, finally, thrombophlebitis, left saphenous vein. She had been running a fever as high as 101 F. and had received large quantities of penicillin, but had continued to have pain, numbness and tenderness along the course of the greater saphenous vein, both above and below the left knee. Ligation had been considered but her physician requested that sympathetic block be used.

Paravertebral block of the left twelfth thoracic and first and second lumbar ganglia was accomplished, with a consequent 3 degree warming of the foot. The patient stated that the pain ceased with the warming of the foot and that her leg felt much better. She was returned to her room and removed from the cart on which the block had been carried out. Shortly afterward, she complained of left precordial pain, also of pain down her left arm. There followed a slight increase in pulse rate, and that evening her temperature rose higher than usual.

An EKG showed no evidence of coronary disease, but a slight cough developed, the patient later spit up some blood, and there were rales in the left lower chest. Dicumarol was given but no antipyretic treatment. There was little or no further trouble with the leg following the paravertebral block, and the swelling and redness subsided.

It seems likely that this patient had a small pulmonary embolus, and her case is cited only to point out that paravertebral block for acute or febrile thrombophlebitis (and certainly with suspected phlebothrombosis) should be performed with extreme caution, without moving the patient from bed, and with minimal disturbance. The legs should be bandaged and bed activity encouraged as fever subsides. Today, in a case of this type, treatment would consist of anticoagulants, and in the face of an elevated prothrombin time neither block nor operation is performed.

All patients who are to undergo novocain block should receive preinjection medication consisting of one to three grains of a barbiturate, since this drug relieves anxiety and counteracts any sensitivity to novocain.

Case Report

Mrs. K. R., aged 31 years, weighed 260 lbs. Her physician encouraged weight loss with diet, and over a period of one year she reduced her weight to 160 lbs. She then first noted swelling and pain in the right leg.

When she was referred to us, the right leg was cold, blue and swollen, and was tender in the calf and along its blood vessels.

Temperatures: Right foot 24 degrees; left foot 29 degrees.

Oscillographic: Left calf 3°; right calf 0.1°.

Measurements: Left calf 37.5 cm.; right calf 40 cm.

Dorsalis pedis pulse: Left, good; right, questionable.

With paravertebral novocain block of L 1 & 2 right lumbar ganglia, the temperature became 29 degrees on the left, 32 degrees on the right. Both dorsalis pedis arteries were actively pulsating. The patient received repeated paravertebral block with novocain and later with nupercaine in oil. She improved symptomatically and objectively, and returned to her home.

She was seen on two occasions afterward, with more symptoms, and finally right lumbar sympathectomy was carried out through a transverse right abdominal incision just above the level of the umbilicus, using the retroperitoneal approach.

Three months later a similar condition developed on the left, for which the treatment was the same, that is, left lumbar sympathectomy.

When seen one month after the second operation, the patient was free of pain, her feet were warm, and her only complaint was slight swelling when she did not wear elastic stockings.

Sympathectomy in the Male

Bilateral lumbar sympathectomy in the case of the male patient sometimes produces sterility through loss of ejaculation, but not impotence. Indications for surgery, however, must be more carefully considered in these cases. The patient must be told of the probability of sterility; also, his personality makeup must be carefully evaluated by the operating surgeon since male patients reportedly have shown signs of depression and psychologic change postoperatively.[17]

Raynaud's Disease

In progressive Raynaud's disease, although the disease possibly is a local disorder and one primarily vascular, the patient usually is benefited symptomatically by removal of the sympathetic influences supplying the affected extremities.[18, 4] After sympathectomy, the digits retain the ability to become white with cold and red with warmth, but there is little pain and there is less danger of trophic disturbance.

It is evident that the prolonged abnormal occlusive response of the capillaries and arterioles of the nonoperated Raynaud's extremity is distinctly reduced after preganglionic sympathectomy of the involved limb. Recurrence of symptoms may take place, however, while the extremity still is warm and dry.

Case Report

Mrs. L. M. P., aged 33 years, was admitted to the hospital on October 14, 1946, with a history of severe pain in the fingers, with blanching and pallor of the skin when she was washing, particularly in cold water, of approximately one week's duration. She previously had noticed some blueness of the hands. When not in water, the hands remained moist from excessive perspiration.

Testing the hands with cold water reproduced the typical cyanosis and later pallor, with subjective symptoms of discomfort, which characterize Raynaud's disease.

Smithwick type ramisectomy, bilateral, of Th. 2 and 3 was carried out. After each side was operated on, the homolateral hand became warm and dry and the arm painless. The patient remained symptom free until December, 1947, at which time she noticed that when using her hands in cold water there was a sensation of coldness but only slight blanching. Otherwise, however, her hands were still warm and dry.

Tobacco and Peripheral Vascular Disease

As is well known, tobacco, when used, adversely affects the course of peripheral vascular disease, so that if possible, its use is stopped, as one of the first measures in treatment. When this is accomplished, the effect of a single paravertebral sympathetic block with novocain is sometimes striking and permanent. In a previously reported case,[13] the patient who had the cold, blue, perspiring hands and aching fingers of true Raynaud's disease received in the upright position injection of both stellate ganglia with 2 per cent novocain by the posterior route. Horner's syndrome appeared on both sides and the patient's face became warm and dry, but the hands remained somewhat cool. Then, gradually, both hands became warm, red and dry. The patient was relieved of her pain and although sympathectomy was advised, she did not return. One year later her sister reported that her hands had improved so much following the one injection that she did not want nor need an operation.

Case Report

W. M. U., aged 60 years, came to the Bluefield Sanitarium complaining of blue, painful fingers of eight days' duration, also of a trophic lesion of the little finger of one hand.

Too old for the onset either of true Raynaud's or Buerger's disease, yet with obvious peripheral vascular spasm, he was treated in the manner in which we treat younger persons with less arteriosclerotic change. The use of tobacco was stopped. Two paravertebral novocain blocks of the second and third thoracic sympathetic ganglia on both sides were carried out at 2-day intervals, producing excellent warming and dryness. The color of the hands remained better. healing process of the trophic ulcer began, and pain was diminished.

Two weeks postinjection, the patient still was objectively improved and symptom free. With no smoking, he had remained well at last report.

A Contraindication to Sympathectomy

In advanced obliterative arterial disease, sympathectomy may be contraindicated because of the danger of delayed gangrene. Occasionally in these cases the major arteries already are blocked, and it has been shown that destroying the vasomotor tone of the arteriovenous anastomoses causes too abrupt shunting of the blood into the venous system, with resultant ischemia.[12] Sympathetic block and sympathectomy are accepted procedures for true causalgia. The frequently associated hyperhidrosis and cold, blue fingers usually are relieved as well.

Case Report

R. E. M., aged 38 years, received a bayonet wound of the left side of the neck and the volar aspect of the left forearm in 1942, and shortly

afterward was taken prisoner by the Japanese and remained so for 3 years.

The patient reported that his left arm was paralyzed and cold for 1½ years and then regained some function but remained weak and painful. He stated also that he had beri beri while in prison. In 1945, he was liberated, returned to the United States and, during the rehabilitation process, made an attempt at suicide, which act was attributed to his state of malnutrition. Insulin shock therapy and feeding ended all such desires.

He was admitted to the Bluefield Sanitarium on January 14, 1947, complaining of severe aching pain in the left arm.

On examination, there was muscle atrophy but reflexes were normal. There was 70 per cent weakness of the left hand and the hand was cold, blue and wet. There was normal sensation except over the area of the bayonet wound of the neck. There was no pulse at the wrist and no oscillographic movement was noted.

Paravertebral novocain injection of the left second and third thoracic ganglia produced 3-degree warming of the hand, normal color, and loss of perspiration.

Following the paravertebral block, the patient ceased to complain of pain and, although the oscillographic needle still barely moved in testing the left arm, insisted on being discharged without operation.

When seen on March 4, 1948, he reported slight pain and numbness of the left arm, but that all symptoms had disappeared for more than a month and that the degree of discomfort still was so slight he preferred not to undergo operation.

Phantom Limb Pain

On the other hand, phantom limb pain often is not relieved either by sympathetic block or by sympathectomy, and this fact is particularly pointed out at the moment because an attack on the sympathetic nervous system apparently still is thought of as the operation of choice for the relief of this condition.

Case Report

Mrs. R. L. S., aged 44 years, underwent a pelvic operation on June 4, 1947 in another hospital. One week later pain suddenly developed in the right arm and the arm became paralyzed and cold. She was transferred immediately to a large teaching hospital where, despite repeated stellate ganglion block, gangrene of the right hand developed and amputation through the midforearm was performed on July 26, 1947.

On September 7, 1947, a conventional Smithwick type dorsal sympathectomy was done on the right and this seemed to afford considerable relief for the time being. Later in the month, however, the patient again complained of some pain but was discharged the following day, with instructions to return for check-up examinations. She failed to do this.

On October 27, 1947, she was brought to the Bluefield Sanitarium because of her complaint of constant pain in the amputation stump and phantom limb pain and the necessity of obtaining relief. A member of her family reported that both family and patient were worn out and willing to accede to anything that would afford relief for the patient.

Examination of the midforearm amputation stump showed it to be in good condition. Oscillographic tests of the stump and arm showed no pulsation, but pulsations of the brachial artery could be felt high in the axilla. Horner's syndrome was present on the right and there was slight hypoesthesia along the ulnar aspect of the arm. The patient did not sleep, constantly nursed the stump, and on the whole was a pitiful case.

As far as we could tell from the dryness and warmth as well as the absence of sweating, sympathectomy of the upper arm and stump was complete. Injection of the main nerve trunks of the upper arm with alcohol, under direct supervision, produced numbness but failed to relieve the phantom limb pain.

On November 18, 1947, bilateral prefrontal lobotomy, with the sections just at the anterior edge of the sphenoidal ridge, was accomplished without incident. Two days postoperatively, the patient was up and about, in the ward. For one week, while she was in the hospital, she did not complain of her arm and even became interested in her fellow patients' conditions.

One month after operation, December 17, 1947, the family reported that the patient was cheerful and the patient herself stated that she felt much better. Her weight had increased from 78 to 94½ pounds; she was helping with the housework, sleeping without sedatives, and living a normal life.

Prefrontal lobotomy may be considered, perhaps, a technique of surgery of the sympathetic system, since the frontothalamic fibers are sectioned.

Blocking or removing the sympathetic nerve supply to a limb that remains painful or swollen after treatment for fracture has proved extremely effective in the relief of these symptoms as well as in the relief of Sudeck's atrophy in similar circumstances.[25]

Case Report

Mrs. J. S., aged 50 years, fractured the left fibula at the ankle. Although bone healing took place in the usual time, there remained slight swelling of the ankle, and walking was so painful that even after several months had elapsed the patient still insisted on using crutches. Lumbar sympathectomy resulted in reduction of the swelling, subsidence of the pain and full ambulation in a 2-week period.

Presacral Neurectomy

Although failure or only transient relief at times is said to follow presacral neurectomy for distress of interstitial cystitis and bladder tenesmus, encouraging results are reported in the literature and the following case illustrates its occasional usefulness and success.

Case Report

Mrs. W. W. C., aged 42 years, was referred with the diagnosis (made by competent urologists) of interstitial cystitis. She was referred for relief of pain and bladder tenesmus. Maximal bladder capacity was 100 cc., and she was voiding approximately every 45 minutes. So severe was her pain that she was resorting to opiates in varying quantities.

Presacral neurectomy was carried out as thoroughly as possible, and recovery was uneventful.

The following note was recorded by the referring urologist three months postoperatively: "The patient states that so far as her bladder is concerned she is getting along very well. She has no bladder discomfort and is voiding about once every hour, or sometimes a little over. The only discomfort which she now has is a little pain which she describes as in the perineum, sort of between the rectum and vagina. Bladder capacity is still just over 100 cc."

Presacral neurectomy in cases of intractable menstrual pain may be of great benefit, or it may be useless in the hands of a "too ambitious" operator.[19] The procedure is strictly for the carefully selected case and the surgeon should know first of all that the patient's pain is real, that she herself is emotionally stable, or relatively so, at least between her menstrual periods, and that she has no reparable abnormality of any of the pelvic organs causing the dysmenorrhea. Again, at the time of operation, it must be remembered that in 80 per cent or more of these cases, the patient reportedly has a plexus type of presacral sympathetic supply, and that all of these fine nerves over the brim of the pelvis, even under the iliac vessels and well down close to the bladder wall, must be removed. Thoroughness is important. A survey of these cases in our hospital indicated that with careful selection and careful technique, the operation can be recommended, but that with any deviation from these rules its recommendation is questionable.

Hypertension

Sympathectomy for hypertension has passed through a number of stages and has both champions and skeptical reservists among those who have used it and studied its effects.[14, 24]

Because of the fall in blood pressure which occurred with spinal anesthesia, Adson[1, 2, 3] first sectioned the anterior spinal nerve roots from the sixth thoracic to the second lumbar. This was an heroic procedure and he tried to accomplish the same result by sectioning the splanchnic nerves and removing the first and second lumbar sympathetic ganglia. Peet[21] established the procedure of supradiaphragmatic splanchnic and sympathetic resection. He advocated it as being all the operation that was necessary for the relief of hypertension. Crile, Sr. denervated the adrenals in an attempt to obtain the same result. Smithwick described thoracicolumbar sympathectomy a more extensive procedure, and Grimson advocated sympathectomy to include the entire thoracic chain bilaterally, below T 3, as well as the first and second lumbar ganglia. It seemed reasonable to agree with Mitchell that the operation of choice should attempt to achieve the following:

(1) Produce widespread vasodilatation of the greater part of the abdominal splanchnic area.

(2) Denervate the vessels of the lower limbs in order to produce somatic dilatation in these parts.

(3) Denervate the kidneys.

(4) Denervate the suprarenal glands.

Also, the operation's mortality rate should be as minimal as is consistent with these results, the operation should produce as few undesirable sequellae as possible, should prevent nerve regeneration, if possible, and probably should be preganglionic rather than postganglionic.[14, 24]

All operations in our clinic followed the thoracicolumbar procedure of Swithwick.[24] Preliminary to operation the prospective patient was thoroughly studied on the medical service, the hypertension history was investigated, blood pressure was recorded several times a day over a period, repeated urine examinations were made, a Mosenthal concentration test done, routine blood studies and nonprotein nitrogen determinations made, and careful studies of the optic

fundi recorded. A number of the patients were subjected also to a test with 3.5 Gm. of sodium amytal intravenously and, when indicated, bilateral pyelograms and electrocardiograms were made.

All our patients in the cases we selected were 45 years of age, or under. Blood pressure in each case was 200 mg. Hg. systolic and over 100 diastolic, by repeated readings preoperatively. In no case with the NPN over 40 mg. per cent, but most showed some albuminuria and in some cases there were a few blood cells in the urine. In several cases the patient reported difficulty with vision, but in only one did the patient show outstanding retinal arteriosclerosis.

One patient had retinal hemorrhages, extremely severe headaches, and convulsive seizures. Her operation was undertaken against our better judgment, at the urgent request of the family. She died of uremia, after going home following a right sided Smithwick type sympathectomy, and before the second side could be operated upon. Hers was the only surgical death in our series.

As stated, we used the classical Smithwick procedure and removed the thoracic sympathetic chain from above the ninth ganglion, all splanchnic nerves, often as high as the sixth thoracic level, the celiac ganglion and the first and second lumbar ganglia on both sides. In all instances but one, the kidney poles were palpated for tumor and all large fibers to the adrenals were resected. The one exception was a case in which the blood pressure dropped excessively after the supradiaphragmatic portion had been done on the second side, so that we did not go below the diaphragm on that side. It is not included in the eight cases to follow, although the result seemed about as good as that in some of the others. Even though our operations seemed complete and extensive, some of the results were not really satisfactory and we were led to wonder about the enthusiastic reports of others.

Illustrative case reports in brief summary form covering eight consecutive cases follow:

Case 1.—Mrs. L. H., aged 39 years, complained of headache and dizziness which were incapacitating.

Preoperative findings: B. P. 254/134; achlorhydria; previous congestive heart failure; albuminuria (50 mg.) had been present.

Postoperative B. P. (2 years); 200/130 lying down 170/120 standing. Patient felt better and could do light work. The operation scar on the right occasionally was painful. She frequently became depressed, worried, nervous and jittery.

Case 2.—Mrs. W. G. M., aged 27 years, had a preoperative B. P. of 230/130, severe headache, occasional nausea, and a drinking husband. The hypertension began with the patient's only pregnancy.

NPN 40 mg. per cent, but there was good concentration of urine, with albumin (35 mg.). There were extremely questionable and inconclusive retinal changes.

Findings postoperatively: Less headache. B. P.: 224/168 reclining; 200/160 standing. There were progressive retinal changes, and the urine still showed albumin.

Later, this patient went elsewhere and underwent a more complete thoracic sympathectomy. Her surgeon wrote me that her pressure when he saw her was 260/150. He resected the sympathetic chain from T3 to T9 on both sides. He stated further, "I am very sorry to state, however, that so far as one could tell from her postoperative blood pressure readings, she will probably get very little result from this extensive sympathectomy."

Case 3.—Mrs. G. H., aged 45 years, had periodic numbness of the left side, severe headache, blood pressure 180/110 ten years previously, and preoperative blood pressure of 228/120. EKG and pyelogram normal. No albuminuria.

Postoperative B. P. reading 1-14-48: 175/100 both arms. No headache; weight 172 lbs.

A note recorded by the medical service: "Patient doing fairly well. Occasionally has spells of syncope, especially on changing posture quickly."

Case 4.—Mrs. J. E. P., aged 45 years, had occipital headaches and nervousness. Preoperative B. P.: 260/124. Albuminuria (10 mg.). She received thiocyanate treatments, with blood level of 6 to 8.8 mg. per cent, without relief.

Findings postoperatively: Quite frequent but less severe headaches; B. P. 210/126; weight 168 lbs.

Case 5.—Mrs. H. E. C., aged 40 years, had B. P. of 256/140, also menorrhagia. She had received radium therapy for the menorrhagia (50 mg. radium inserted in uterine cavity), with no relief. Bilateral pyelogram was normal.

Findings postoperatively: B. P. 200/128 sitting; 178/124 standing. No headache. Menstruation normal.

Case 6.—Mrs. G. K., aged 38 years, had had chronic nephritis, retinal hemorrhages and convulsions. We had no business trying to operate

on her but did so after informing her of the probable futility, also on being further urged to operate on her by her family and her physician. Preoperative B. P.: 250/170. B. P. after right thoracicolumbar sympathectomy, when discharged, ambulatory, November 27, 1947: 220/150.

The patient was readmitted on December 10, 1947. B. P. 210/139, with evidence of beginning cardiac decompensation. Her course was progressively downhill and she died on December 20, 1947, of uremia.

Case 7.—Mrs. L. W., aged 39 years, had persistent headache, vertigo, nervousness and B. P. of 208/120.

Postoperative condition: No headache and no nervousness. The patient had returned to her work in a restaurant. B. P. 170/94. Operation scar on right occasionally a little painful when she is fatigued.

Case 8.—Mr. H. E. C., aged 37 years, had headache, nervousness and difficulty with his eyes.

Preoperative B. P.: 228/150. Urine showed albumin (175 mg.), also 1 to 2 red cells. Vision was reduced to 20/100, left eye; 20/30, right eye. There were sausage-shaped constrictions of the retinal vessels.

Postoperative findings: No headache; practically no nervousness. B. P. 158/120 sitting; 140/120 standing. Vision: Right 20/25; left 20/50.

When last seen, the patient had given up his work as a teacher and had gone to work in a machine shop.

Comment

In review, most of these patients' symptoms of headache, dizziness, blurring of vision and transitory cerebral vasospasm were improved by the operation. Instead of these symptoms, some of them had substituted giddiness on change of posture, paresthesias in the distribution of their twelfth thoracic nerves, and the occasional sense of dyspnea on active exertion.

None of the eight patients maintained a postoperative blood pressure of 140/90 or lower, which was considered normal. On the other hand, with the exception of one patient who died of uremia and one (Mrs. W. G. M.) who went elsewhere for more extensive operation, none became worse in the year following sympathectomy. Progression of symptoms apparently was slowed down or stopped and most of the patients probably lived longer than would have been the case without the operation.

Since the advent of effective antihypertensive drugs, operations for hypertension have become rare in our hospital, but for the occasional patient who is young and does not respond to drug therapy for essential hypertension, sympathectomy may add the therapeutic touch which will save or prolong life.

Summary and Conclusions

1. Sympathetic block with novocain is useful in the treatment of herpes zoster, Raynaud's disease, causalgia, erythromelalgia, thrombophlebitis and spasm associated with arterial occlusion.

2. When novocain block is effective but the effect of insufficient duration, alcohol block or sympathectomy should be considered.

3. Sympathectomy is not recommended for retinitis pigmentosa, megalocoly, or other mega syndromes.

4. Presacral neurectomy is useful in carefully selected cases of dysmenorrhea and bladder pain.

5. Sympathectomy for hypertension still may be used in selected cases of resistant essential hypertension, but those using it should recognize its limitations.

6. The possibility of delayed gangrene following sympathectomy in cases of advanced obliterative arterial disease should be borne in mind and the situation carefully evaluated.

7. Sympathectomy and sympathetic block with drugs are both useful and justified in the treatment not only of Sudeck's atrophy but in those cases of persistent pain or swelling following fracture of the long bones.

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Must History Be Repeated?

Great Britain has announced that its national medical care program cost 2.2 billion dollars in the past fiscal year. This is almost double the amount spent ten years ago. She was required to borrow about a half billion dollars from the United States. She found that this medical welfare state has grown beyond her ability to support and she is therefore making an effort to cut back in order to stave off a devaluation of the pound.

In addition, Great Britain has observed that its British-trained physicians are leaving their country at the rate of about six hundred per year. The supply of physicians is maintained by an influx of foreign physicians largely from India and Pakistan. The British-trained physicians prefer to move to Canada or the United States where their practice is not under government control. They feel that they cannot afford to live on the low wage scale provided by the government which pays only $1306 as the starting pay for full time hospital work. It seems ironic that the United States should be loaning a half billion dollars to Great Britain to finance an ailing welfare medical program while at the same time this administration seems determined to enact a similar program.

In medicine, as in most other things, we get what we pay for. If the British government is undertaking to provide free health care for everyone, and at the same time support an administrative bureaucracy, it might be expected that the best doctors will have a tendency to depart or leave the practice of medicine, and that the quality of medical service will deteriorate. Santayana has reminded us that those who will not learn from history are condemned to repeat it.—Carl O. Rice, M. D., in Minnesota Medicine.

Leukoplakia of the Renal Pelvis*

D. Franklin Milam, M. D.

Leukoplakia of the urinary tract is relatively rare. Rokitansky,[1] in 1861, first described its occurrence in the bladder, while Ebstein,[2] in 1882, reported its involvement of the renal pelvis. Beer,[3] in 1914, reported the first case of leukoplakia of the renal pelvis in the United States. After a review of the literature, Abeshouse,[4] in 1956, observed that in only three previous cases had the diagnosis been made preoperatively. Politano,[5] in 1956, reported that in a survey of 7,500 autopsy reports and 288,887 case records at Duke Hospital, no case of leukoplakia of the renal pelvis was found. McCrea[6] made a survey of 36,000 autopsy reports and 251,578 discharges at Philadelphia General Hospital for the 12-year period from 1936 to 1948 and did not find a single case. Scott and Thomas,[7] in 1959, reported 3 cases in which the diagnosis was made preoperatively and observed that prior to 1959 only 6 cases had been diagnosed before operation.

Etiology

The etiology of leukoplakia of the urinary tract is unknown. Landes[8] suggested that chronic inflammation, chronic irritation, chemical stimulation, vitamin A deficiency, syphilis, congenital cell rests, all might play a role.

Pathology

Senger[9] stated that the basic pathologic process is squamous metaplasia of the epithelium of the renal pelvis and calyces, with keratinization. Kutzmann,[10] citing Rokitansky,[1] stated: "In the inflamed bladder, there occurs occasionally an epidermoid production, at times circumscribed, at other times occupying the whole mucosa of the urinary apparatus; it produces an abundant desquamation of thick scales, stratified, white, shiny, in the form of cellular epidermoid plates; the adjacent mucosa is chronically inflamed and villous."

Beer,[3] in his description of the first case of leukoplakia of the renal pelvis in the United States, remarks: "Microscopically the urine was normal in color, but floating around in it were pearly white membranes looking like paraffin shavings, about one-fourth inch square, rolled on themselves, and settling slowly on standing. The membranes were further examined under the microscope and showed a picture of surface exfoliated epidermis."

The Author

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Diagnosis

Kretschmer[11] observed that there was no symptom nor syndrome by means of which the condition could be diagnosed. According to Armstrong,[12] infection precedes and accompanies almost every case. Armstrong states further that

Figure 1. Retrograde pyelogram showing filling defects of renal pelvis and ureter.

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Submitted to the Publication Committee, February 2, 1962.

a typical filling defect of the renal pelvis or the calyces, cornified squamous epithelial cells in the urine and a history of infection should cause one to consider leukoplakia in the differential diagnosis.

Treatment

Nephrectomy has been the treatment of choice in most cases reported to date. Helfert,[13] in a case involving the urinary bladder, used ACTH and found that the leukoplakia disappeared and the patient became asymptomatic. Many local treatment methods such as silver nitrate instillations, zephiran instillations, large doses of vitamin A, and antibiotics have been described in the literature.

Case Report

L. M., a 68-year-old white female, was admitted to the hospital on May 10, 1959, with a chief complaint of cramp-like abdominal pain and distention of two weeks' duration. She was a known 30-year hypertensive. There also was a history of a mild coronary occlusion (1955) and of thyroidectomy (1938). Her health recently, however, had been good. Since 1955 she had been taking digitalis daily. Except for occasional dysuria, there had been no urinary tract symptom.

Physical examination revealed a thin, somewhat pale, but well developed female. The abdo-

An electrocardiogram showed first degree heart block with left ventricular hypertrophy.
men was soft. There were no palpable masses. B. P. 194/110 in both arms. There was pitting edema (1 plus) of the ankles.

NPN 37 mg. per cent; serum electrolytes normal. Hemoglobin 12.7 Gm., hematocrit 37 per cent. WBC 6,500, with a normal differential. Blood serology negative.

Urinalysis revealed specific gravity of 1.008. There was no albumin, no sugar, no casts. There were 2 to 3 RBC and 6 to 8 WBC per hpf, with many squamous epithelial cells and many bacteria in the routine analysis.

A cholecystogram revealed numerous small, radiolucent stones in the gallbladder. Stomach x-ray showed no abnormality. An intravenous urogram showed normal function of the left kidney, with a mass in the region of the right kidney pelvis. There was a filling defect of the right ureter in its upper third and an additional defect resembling metastasis in its middle third.

Cystoscopy on May 22, 1959, demonstrated no abnormality of the urinary bladder. A catheter was inserted into the right renal pelvis and clear urine (20 cc.) was obtained for cytologic examination. A complete pyelo-ureterogram revealed lack of filling of the middle calyx of the right kidney, with distortion of the kidney pelvis. A mass in the middle third of the right ureter was thought to be a metastatic tumor.

The cytologic examination disclosed typical squamous cells with many leukocytes. There were many bacteria but no atypical cells.

The preoperative diagnosis was cholelithiasis, hypertension and probable papillary carcinoma of right renal pelvis with ureteral metastasis. It was felt that transabdominal nephroureterectomy, with simultaneous cholecystectomy was the procedure of choice.

At operation, the gallbladder was easily removed. The right kidney was exposed through an incision in the posterior peritoneum. A firm mass was felt in the midportion of the kidney, with a second mass in the ureter at the point at which it crossed the iliac artery. The kidney with its capsule and perirenal fat was delivered from the renal fossa. The ureter was isolated to the point at which it entered the bladder and was then ligated and cut. The abdomen was closed in layers without drainage.

There was no complication postoperatively, and the patient was discharged from the hospital

Figure 2. Gross specimen of kidney and ureter demonstrating desquamated keratin masses in calyces, renal pelvis and ureter.

on June 5, 1959. Her blood pressure at that time was 170/100.

Pathologic Description of Kidney

Pathologic examination of the right kidney showed that it measured 10 X 6 X 3.5 cm. An attached portion of ureter measured 18.5 cm. in length. There was a moderate amount of perirenal fat. The renal capsule was pale grey, smooth and transparent. The external surface of the kidney was pink and showed irregular depressed areas. On section, the renal pelvis was filled with pale grey, soft, glassy, laminated material. There was a 2.5 X 1.3 cm. oval shaped mass of similar material in the lumen of the ureter at a point 10.5 cm. from its origin. Of the kidney's three major calyces, the middle calyx was greatly distended, compressing the surrounding parenchyma, and filled with material of the same type as that filling the renal pelvis. The mucosal lining of the calyx was yellowish-white and slightly roughened, with attached patches of laminated material similar to that in the ureter and pelvis. The remainder of the mucosa of the renal pelvis was whitish and grossly not remarkable.

Microscopic section through the entire thickness of the kidney showed a well organized cortex. In one area, the tubules were distended and contained eosinophilic homogeneous colloid-like material. The glomeruli were not abnormal. The arterioles showed thickening and hyalinization. Numerous multinucleated epithelial giant cells were seen at the level of the proximal convoluted tubules. The pelvis was lined with keratinized stratified squamous epithelium. The contents of the pelvis consisted of laminated keratin.

The pathologic diagnosis was cholelithiasis, chronic pyelonephritis and keratinizing leukoplakia of the pelvis of the right kidney, with obstruction of the calyces and ureter by keratin masses.

Summary

A case of leukoplakia of the renal pelvis, in which the pelvis and ureter were filled with desquamative keratin masses, is reported.

Since the urine specimen contained squamous epithelial cells on several occasions, and urine from the right kidney pelvis showed numerous squamous cells on cytologic examination, we considered that the case could be one of leukoplakia of the renal pelvis. In the presence of filling defects of the ureter, however, it seemed to us that the most likely diagnosis was carcinoma of the renal pelvis with extension to the ureter.

Figure 3. Microscopic section through renal pelvis illustrating keratinized stratified squamous epithelium.

A typical renal filling defect associated with a history of infection and squamous epithelial cells in the urine should cause us to consider leukoplakia in the differential diagnosis.

In cases in which the disease is unilateral, the treatment is nephrectomy.

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Gastric Fluid Aspiration Fatally Complicating Amniotic Fluid Embolism*

(Case Report)

Geza Z. Gaal, M. D., and Benjamin Newman, M. D.

ALTHOUGH the outcome of amniotic fluid embolism is fatal in almost all instances, a few presumptive sublethal cases have been reported.[1] Gastric fluid aspiration as a complication of amniotic fluid embolism can jeopardize even this extremely slim chance of survival.

Since Meyer's[2] first description, in 1926, of amniotic fluid embolism and its lethal possibilities, many excellent and comprehensive studies on the subject have appeared. The combination of gastric fluid aspiration and amniotic fluid embolism, however, was not reported until 1959 when Best and De Profetis[3] first described a case. Since no further report has called attention to the possibility of such a combined crisis, it seems in order to report the following case.

Case Report

A 25-year-old white female, gravida 4, para 3, was admitted to the obstetrical department on December 21 at 6 P.M., in labor. Her past medical history and her family history were negative. No surgery nor allergies were recalled. There was no history of premature delivery nor of abortion. The patient's youngest child, 4 years old, was delivered in our hospital without incident.

Menarche was at age 12; regular menstrual periods occurred every fourth week, with duration of 4 to 5 days. Previous pregnancies, labors and puerperiums were normal. The last menstrual period was March 14, quickening was first experienced in the last week of July, and the expected date of confinement was scheduled for December 21. The course of the present pregnancy had been without complication.

Prenatal examinations had revealed normal blood pressure values, normal urinalyses, negative serology and a total weight gain of 40 pounds. The patient's blood type was A, Rh. positive. Her pelvic measurements were within normal limits. Onset of labor occurred on December 21 at 4 P.M., two hours prior to admission. Presenting part, the vertex, was fixed. The location of the fetal heart was in the left lower abdominal quadrant, with a rate of 143 per minute. Patient's blood pressure 120/70, pulse 98, respiration 20. Temperature 98.8 F. Pelvic examination disclosed a soft and thinning cervix, with a 3 to 4 cm. dilatation of os.

Regular but remarkably hard contractions were exhibited every 4 minutes, and 20 minutes after admission the membranes ruptured spontaneously. After 7 P.M., the contractions recurred every minute, their character remaining continuously hard. Pituitary extract was not administered. At 7:30 P.M., the cervix became fully dilated and the patient was taken to the delivery room where nitrous oxide-oxygen-ether anesthetic was administered. At 7:40 P.M., a fully matured viable male infant was delivered spontaneously from left occipito-anterior position and 4 minutes later an intact placenta was expressed. There was no evidence of tear nor of laceration. Blood loss was estimated at approximately 100 to 150 cc.

At 7:45 P.M., the patient vomited and aspirated. Suction and nasal intubation were instituted immediately by the nurse anesthetist, after which the patient was breathing smoothly and seemingly well for 15 minutes. At 8 P.M., unproductive coughing and restlessness occurred. The patient became very apprehensive and tachypneic. Moist rales were heard diffusely throughout both lung fields. Within a few minutes it was noted that the right hemithorax was expanding poorly, with auscultatory findings of decreased breathing sounds. While preparations

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Submitted to the Publication Committee, February 26, 1962.

were being made for bronchoscopy, the patient became cyanotic and vital signs progressively worse, although oxygen and helium per mask, intravenous aminophyllin and stimulants were administered in the meanwhile.

At 8:45 P.M., bronchoscopy was carried out. The larynx and subglottic space were normal. The lumen of the trachea was reduced as if by external pressure. During the procedure, the patient was breathing rather heavily, with expiratory rhonchi. The bronchial tree contained light creamy liquid which was aspirated together with small fragments of partially digested food particles. No gross pieces of foreign bodies were seen. After the bronchoscope was withdrawn, the main stem bronchi and the immediate subdivisions that were visible to the eye were well opened. A transient episode of improvement in respiration was noted for several minutes but shortly after 9 P.M., marked cyanosis and extremely labored respiration necessitated reinsertion of the bronchoscope in order to disclose whether or not the air-way was still sufficient.

No gross obstruction was found in the main bronchial tree and more creamy liquid was removed through the bronchoscope. Meanwhile, intravenous administration of aminophyllin and coramine was repeated but the vital signs continued to become progressively worse. After 10:20 P.M., the blood pressure dropped to zero and the pulse became undetectable. In spite of the administration of intravenous stimulants, aminophyllin and the terminally given oxygen under positive pressure, the patient expired at 10:30 P.M., four and one-half hours after admission.

Post-Mortem Studies

Autopsy revealed that the peritoneal and pleural cavities were free. The pericardial sac contained 20 cc. of straw colored fluid. The heart weighed 280 Gm. The epicardium was pinkish-gray and smooth, the myocardium was light tan, soft and flabby. The valves and cusps were not remarkable. The aorta and coronary arteries were negative. The pulmonary artery was patent with grayish and smooth intima.

The right lung weighed 700 Gm., the left lung 550 Gm. All lobes were subcrepitant. The pleura was pinkish-gray and smooth. On section, all lobes were wet and edematous, and showed numerous focal and confluent hemorrhagic areas.

Mucosa of the larynx, trachea and bronchi was grayish-pink and focally hemorrhagic. The lumens contained blood-tinged fluid. The stomach contained about 100 cc. of partially digested food. The gastric mucosa was grayish-brown and smooth, and the folds were flattened. The rest of the gastrointestinal tract was not remarkable.

The uterus measured 18 x 12 x 10 cm. and appeared to be postpartum. On section, the myometrium was brownish, the endometrium smooth and reddish throughout. The cervix was boggy and edematous. The rest of the organs revealed no gross abnormalities.

Microscopic studies of interest were confined primarily to the lungs and revealed marked edema with many of the alveoli containing polymorphonuclear leukocytes in their lumina. The alveolar walls were hemorrhagic and edematous and also contained polymorphonuclear leukocytes. The lumina of the bronchioles contained partially digested food particles which were surrounded by numerous pus cells (Figure 1).

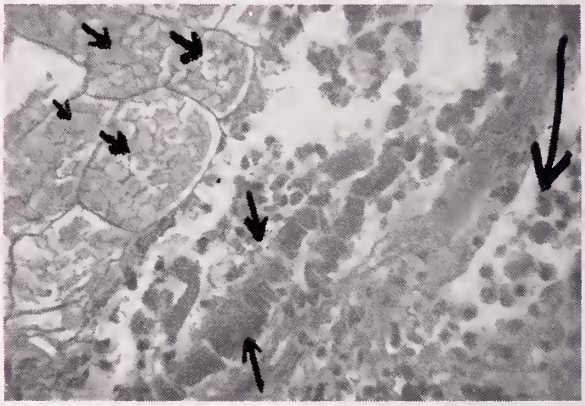

Figure 1. Lung. The small arrows are pointing into the lumens of bronchioles which were filled with starch structures, indicating aspiration of partially digested food particles. Between the medium sized arrows (and in the midportion of the picture) desquamated bronchial epithelial cells are shown. The long arrow points to the pus cells of the remainder of the picture, indicating adjacent acute bronchopneumonia.

The small pulmonary arterioles occasionally contained in their lumens pink-staining amorphous material with epithelial cells, suggestive of amniotic fluid origin (Figure 2).

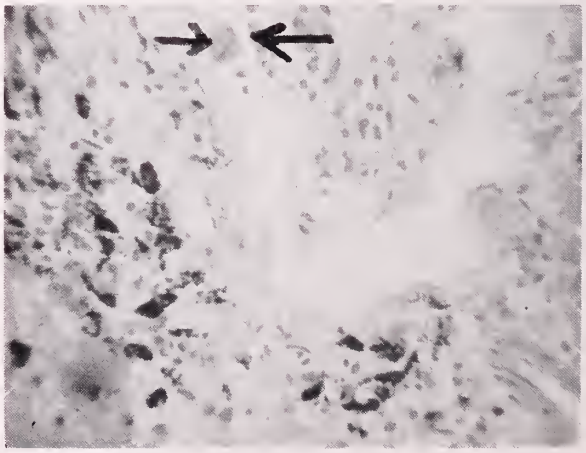

Figure 2. Squame-epithelial cell of amniotic fluid origin shown by the arrows in the lumen of a small pulmonary arteriole.

The rest of the gross and microscopic findings are summarized in the pathologic diagnosis as follows: (1) Amniotic fluid embolism; (2) aspiration of vomitus with marked acute bilateral bronchopneumonia and suppurative pneumonitis; (3) bilateral pulmonary edema with acute *cor pulmonale;* (4) cloudy swelling of the myocardium, liver and kidneys.

Comment

The chronologic recording of the course of events in the reported case suggests that the amniotic fluid embolism was the primary pathologic process, complicated by aspiration of vomitus under obstetrical anesthesia.

Mendelson[3] estimated the incidence of gastric fluid aspiration under obstetrical anesthesia during the period 1932 to 1945 to be 0.15 per cent, which represents 15 cases per 10,000 births. A recent report of Phillips et al.[4] contains a review of 455,553 live births from 1936 to 1958, with the number of obstetrical anesthesia deaths decreased from 3.5 to 1.1 per 10,000 live births In spite of this impressive change in the number of maternal deaths related to obstetrical anesthesia, it is felt that many more cases of fatal gastric fluid aspiration could be prevented.

Prevention

Prevention should start during prenatal care, with repeated reminder and warning to the patient not to eat at home after onset of labor. Food of any kind must be withheld in the hospital while the patient is in labor and this must be strictly supervised. If a parturient patient has eaten within 6 hours, an attempt should be made to empty the stomach artifically if inhalation or intravenous anesthesia is to be used. If this is not feasible, deep general anesthesia should be avoided and local, low dose spinal or caudal analgesia is recommended.[3] This can be augmented, if desired, by the utilization of paracervical and pudendal block.

Death from gastric fluid aspiration usually is regarded as being due to obstruction by food particles, with massive atelectasis, pulmonary edema due to chemical irritation and secondary infection.

In our case, the micropathologic finding of epithelial cells in the small pulmonary arterioles indicated that amniotic fluid embolism preceded the fatal pulmonary changes. Although massive atelectasis did not take place, the chemical irritation by the aspirated gastric fluid contributed to the development of pulmonary edema, and the secondary infection led to bilateral bronchopneumonia and suppurative pneumonitis.

Kantor[5] expressed the opinion that the mother probably can tolerate a small amount of amniotic fluid in the circulation without symptoms. He reported that experimentally, one patient was injected intravenously with 8 cc. of amniotic fluid without demonstrable effect and it was felt that a fairly large quantity doubtless enters the maternal circulation when the catastrophe occurs. It has been postulated, however, that it never is physiologic even for small quantities of amniotic fluid to enter the circulation. Sparr and Pritchard[6] labeled maternal red blood cells with radioactive sodium chromate ($Na_2 Cr^{51} O_4$) and placed them in the amniotic sac as "tags" to aid in detecting, if possible, any transfer of amniotic fluid to the maternal circulation. It was concluded that, normally, practically no amniotic fluid escapes into the circulation.

Amniotic fluid embolism in itself is a dramatic disaster and its complication by aspiration of vomitus can be prevented by constant awareness of the possibility and grave hazards of its occurrence and by the prophylactic measures discussed.

Summary

A case of gastric fluid aspiration fatally complicating amniotic fluid embolism is reported, and probably represents the second case of its kind to be described in the literature.

The importance of preventative measures has been re-emphasized and an augmented plan described for the prevention of such cases.

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Pre-Commencement Exercises
West Virginia University School of Medicine
Class of 1962

Pre-Commencement Exercises for 15 members of the West Virginia University School of Medicine, Class of 1962, were held in the WVU Medical Center Auditorium on Saturday evening, June 2, 1962. Dr. Edward J. Van Liere, Dean Emeritus, was the principal speaker and addresses were also delivered by Dean Clark K. Sleeth and Dr. Kenneth E. Penrod, Vice President.

The Publication Committee is pleased to publish the remarks of the three speakers and we take this opportunity to welcome into our ranks the first recipients of M. D. degrees from the West Virginia University School of Medicine.

It is indeed the realization of a dream and we sincerely hope that these physicians will locate in West Virginia following completion of their internship and residency training.

Kenneth E. Penrod, Ph. D.
Vice President

An occasion such as this is likely to engender a certain amount of mixed emotion. We share with those who long dreamed, planned and programmed the construction of this magnificant facility, the realization of their dream with graduation of the first class; nevertheless, it is a sad occasion for those of us who have been concerned with the early operation of the Medical Center and especially its Hospital as this constitutes a breaking-up of the original team.

You have been in a very real sense an integral part of the original team. It seems now such a short time ago when you were anxiously inquiring whether the clinical staff and hospital would permit the offering of a third year of medicine by the fall of 1960. We attempted to reassure you in the spring of 1960 that such would be the case. There is no denying the facts that many of the clinical faculty had not yet been publicly identified, and the hospital was a far cry from an operating stage. There was reason for doubt. However, you demonstrated your faith in what we told you by making the decision to stay here and receive your clinical training.

I believe that you have had both a unique and a fundamentally sound clinical experience. You have had an opportunity to work at the elbow of the department chairmen to an extent unlike that of your fellow men anywhere in the country. At times you have been forced to put in long hours and seemingly exhaustive work. But you have been amply rewarded.

It is within the power of those of us here to make this a reasonably good School of Medicine. The greatness of any school depends upon the accomplishments of its alumni. We now ask you to go forth—and we know you will—and make this a *great* school!

Clark K. Sleeth, M. D.
Dean

Members of the West Virginia University School of Medicine Graduating Class of 1962, what I now have to say is addressed to you.

On occasions such as this it is commonly expected, and I believe appropriately expected, that the Dean may have some final counsel to offer. In a sense, words at this time should be unnecessary. The precept and example of your teachers, and the learning experience which it has been your unique good fortune to share so intimately with them, leaves little to be said this evening.

Nevertheless, there is one concept which I should like to reinforce in the hope that it will become for each of you a part of the way of life at whose threshold you now stand.

You may be surprised, but should not be, to learn that I turn, in part, to biblical documentation for what I wish to leave with you. The early Christian writer, Paul, in a letter addressed to the Hebrews of his time, has some very interesting comments on the quality faith. Faith, says Paul, is the substance of things hoped for, the evidence of things not seen.

Now you, members of the Class of 1962, whether or not you have consciously thought about it, are no strangers to faith. Where was the West Virginia University Hospital when you enrolled as first-year students of medicine not quite four years ago? Or, two years ago, when you cast your lot to stay with the pioneer group in the new School here, where were the members of the clinical faculty you have come to know so well? Faith, the substance of things hoped for,

the evidence of things not seen, has been a daily factor in the life of each of you.

But to return to the writings of Paul, we find that he enumerates a long list of the Patriarchs of old who achieved, by faith, accomplishments which seemed impossible, and which still today influence the course of human events. He then goes on to say, "They who do such things declare plainly that they seek a country, that is, a better . . ."

A little earlier this evening it was my pleasure to place in the hands of each of you a personal token which I hope may help you continually to see yourself as a part of the company of those who indeed "seek a country." Just as Paul, in his time, enumerated those who had achieved by faith, so have other writers, in other times, recorded for us the achievements of those who have "sought a country" in the service of their fellow men through medicine.

In the whole field of biology, the study of life, of which medicine is a part, the only constant feature is change. Change may be for good or for ill, and we must never equate mere change with progress.

My fondest and most sincere hope for you who stand at a threshold is, that you will hold fast to the substance of things hoped for, the evidence of things not seen, and thus be enabled in the daily practice of your art to declare plainly that you, too, "seek a country."

From him to whom much has been given,
much will be required.

And now, in recognition of successful completion of the prescribed curriculum, and with the recommendations of the faculty of the School of Medicine, I will cause each of you to be invested with the hood symbolic of the degree to be granted you by West Virginia University.

As I read each name, together with your home town and the hospital at which you will intern, will the candidate please present himself for investiture.

Edward J. Van Liere, M. D.
Dean Emeritus

This is indeed a memorable occasion, and it is an honor to participate in these exercises.

Parenthetically I should mention that during the past seventeen years I have attended at least two Commencement Exercises each year. This pre-commencement ceremony is quite different.

I was asked by Dean Sleeth and his Committee on Arrangements, of which Dr. C. E. Andrews is chairman, to say a few words to the students who are about to be graduated. I wish to make clear that this is not a commencement address, because the formal commencement exercises will be held next Monday morning. My remarks for the main part will be of an informal nature.

A few comments on the early history of our Medical School are in order, and I will take you back momentarily 93 years. The State Legislature on February 3, 1867, created an "Agricultural College" of West Virginia. This new institution opened its doors in September, 1868. The following year the name was changed to "West Virginia University." It is of interest that in that year, namely, 1869, a distinguished physician of Morgantown, Dr. Hugh Brock, taught a course in "Anatomy, Physiology and Hygiene." Since then, that is, for 93 years, there has always been at least one man on the faculty who held the M. D. degree.

The two-year curriculum was actually established in 1902, and the school was called, "The College of Medicine." In 1912 the school was put on a somewhat firmer basis and its name was changed to "The School of Medicine." The curriculum, however, was practically identical with that of 1902. The school therefore is 60 years old.

This, of course, is the first time "The School of Medicine" has granted the M. D. degree. But it is of historical interest that there were two periods during the existence of the School when it gave a joint M. D. degree with another institution. From 1902 to 1912 such a degree was given with The College of Physicians and Surgeons of Baltimore, now The School of Medicine of the University of Maryland. Since 1945 a joint M. D. degree has been given with the Medical College of Virginia at Richmond. Indeed, our contract with this school does not expire until June 30 of this year.

Dean Sleeth has emphasized several points, and I wish to repeat three of them, for I believe that a certain amount of reiteration is recognized as good pedagogy. They are: (1) that you graduates are pioneers, (2) that you should be students all your life, and (3) that much is expected of you.

I wholeheartedly subscribe to all these sentiments, but especially the last one, which is so nobly expressed in the St. James version of the Holy Bible: "For unto whomsoever much is given, of him shall much be required; and to whom men have committed much, of him they

will ask the more." (St. Luke, Chapt. 12, verse 48).

In addition, I would stress three qualities which in my judgment a physician should have: kindness, tolerance and loyalty. I wish that committees on admissions had some objective method of measuring these qualities, although I realize that this would be difficult to do. To me, they are of paramount importance.

I will not dwell on kindness and tolerance, because I am sure all know what these qualities mean to a person who is ill. I do want to say a few words about loyalty. I mean loyalty in the widest sense: loyalty to your country, to your fellow men, to your teachers, to your school, and to your profession.

In regards to loyalty to your teachers, we find this sentiment expressed in "The Oath of Hippocrates" (translated from the Greek by Francis Adams, Surgeon, 1849):

> "To reckon him who taught me this art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required."

I grant this is an idealistic approach, but, in the same breath, submit it is a noble one.

I wish especially to stress loyalty to the institution from which you have been graduated, and which made it possible for you to practice your profession. Every one knows that the cost of training medical students is much more than the tuition he pays. This means that the institution has to find money from other sources, and this is not always easy. It behooves, then, every student to remember that his medical education was subsidized to a large extent (actually no one knows exactly how much). He should never forget this, and when he is in a financial position to aid his school he should do so.

Not only should an alumnus help his school financially, but he should aid in other ways. For example, he can refer certain cases to the University Hospital and to members of the staff. In this way the medical students will be benefited. He should take an active part in the alumni association of the school. It is hardly necessary to mention that he should say only good things about his alma mater, but if criticism seems in order, it should be constructive and not destructive criticism. I will not dwell further on the subject of loyalty, except to say that I personally feel that it is one of man's finest attributes.

We have come a long way in medical education in West Virginia. Many of you will recall the small Medical Building which was situated across from the Field House. I must insist (and I hope you will pardon me) when I say that we did a good job in the old Building. Many of our boys and girls who completed their first two years of Medicine transferred to some of the greatest medical schools in our country and they gave a good account of themselves. Indeed, our own Dean Sleeth is one of our graduates.

I am, of course, extremely proud of our new plant and am proud that I had something to do with it. It just so happened that I was Dean of the school at the time and was fortunate enough to have a splendid group of men to work with me.

I am proud of our faculty, both those in the basic sciences and those in the clinical division. It is my belief that soon we will have a great Medical Center, and one of which every citizen in the State should be proud. In order to develop the school fully, however, we need the help and sympathetic cooperation of all the citizens of the state. I earnestly solicit the support of all.

In connection with our clinical staff and hospital staff I would like to read a few sentences taken from a letter which Former Governor Okey Patteson wrote me May 3, 1962. As some of you know, Governor Patteson was recently a patient in our Hospital. It is a pleasure to mention that he has fully recovered.

I must explain that some of the sentences are taken out of context. He writes:

> "You know, of course, that I feel that one of the most outstanding accomplishments of my administration was the establishment of the four-year medical school, and I predicted that it would be a most outstanding institution. Now that I have been a patient there, I can personally vouch for the fact that all of you are doing a wonderful job in every respect.
>
> "The efficiency and courtesies of the entire staff and all the workers instill in a patient a feeling of confidence and well-being that contribute greatly to his rapid recovery.
>
> "My sincere thanks to all of you for the wonderful care and attention I received, and the many courtesies shown my wife who, of course, spent every day with me in the Hospital."

How fortunate you graduates are that you all got to know your clinical teachers so well. Many medical schools admit 100 students or more in the first year class, and, indeed, there are several schools which admit 200 students. I am sure that all can appreciate what little contact such a large number of students can have with the heads of the large clinical departments.

You 15 graduates cannot fully realize that the granting of the M. D. degree is a great personal pleasure to the men who have dreamed and labored so long to make this happen. The opportunity of helping create such a facility for

one's state is not given to many. This commencement is the first milestone on the long road to the best medical care possible for West Virginia.

I draw to a close. I join Dean Sleeth and Vice President Penrod in extending my congratulations to the graduating class, and this includes the wives and sweethearts. I hope you graduates will choose to practice in West Virginia. The State needs men and women of your training and caliber. In closing, I would like to quote a line from one of the songs which has been sung for many, many years at Eton, the famous English college. The line is: "Keep the torch burning and hand it on."

Hail and Farewell

Frederick R. Whittlesey, M. D.

Members of the first graduating class at the West Virginia University School of Medicine were honor guests at a banquet given by the members of the faculty of the School of Medicine.

Dr. Frederick R. Whittlesey of Morgantown was the principal speaker at the function which was held at the Hotel Morgan on May 29, 1962.

My friends, and especially you members of our first graduating class, Greetings.

This occasion is a solemn one, but even more is one of great sentiment, for you and all of us here. It is marked for many all over this State, in all walks of life, who have sacrificed time, energy, and unrecorded money to this—the achievement of their dream. Yes, people had a dream, and, if enough people dream the same dream I guess it sometimes comes true. They dreamed the same thing in different ways; some of where the school should be, some of how to finance it, some of how to plan and build it, and some of how it should be staffed and how the curriculum should be. Some dreamed of all these things at different times. I remember early in the game, when I was a member of the Council of the West Virginia State Medical Association, how my own thoughts had all been along the lines of location, staffing and objectives. Then at one of the meetings one or two of the doctors had the possible revenue source figured out—the blessed "pop tax." You see what I mean about dreaming in different ways.

I remember the ceremony of ground-breaking down by the Chestnut Ridge road, in the pasture. Some of you were there. It wasn't a big crowd, but there was a variety of people from Governor Patteson down. Some, like the Governor, had come quite a distance; most were just local folks, a cross section of the town. It was a simple but moving ceremony to me, and I got down in the pit and turned my shovelful with pride, as did many others. We still have that shovel; they have it on display in the lobby at times. Who could then have thought that it would spade up the tremendous place we know now. In a way, it seemed a foolish and impossible dream. No one knew what it would be like, or whether it could grow. And now look!

Many, many months of time went into the planning, so much time, that lots of us got restive. When were things going to start? Those essential planning months were well spent, as we all know. At last the Basic Sciences Building was done and dedicated, and the School moved in. What a dreary, lonely place it was! No life, or not enough. Would time ever provide a thronging population for these empty halls? One felt at times like Shelley's traveler from an antique land—people had been here once, it seemed, but they had all gone long ago, and one was alone in a desert, where "the lone and level sands stretch far away." Now every year sees more and more life; people keep coming from all over the State, all over the country, all over the world. To the firm foundation of the first two years has been added the solid structure built by the clinical people. They too have a vision and a tireless devotion. Without these they would not have come here, and to them you owe an equal debt.

This sentimental occasion is also one, for me, of envy—envy of you the first graduates, who have had so much broader and more thorough training than fell to any of us way back there in the twenties. You have also been given so much

more responsibility than we were given, so that you finish up your four years with much more skill and knowledge than we gained then in five.

Of course, there is one thing you possess that we too possessed long years ago—you are now positively, and for a year or two more, at the pinnacle of knowledge. You know more now about medicine in all its branches than you ever will later, more than any of your teachers (who after all know only their special fields), and more, of course, than the ordinary run of doctors. But think of it, you are now all eligible to join us. In fact you are doomed and destined, most of you I hope, to become "local physicians," or "LMD's," and it is a noble calling. As nearly as I can figure it, we are local physicians in the eyes of doctors who are somewhere else, so we are all bound to be local physicians.

A lot of the work doctors have to do is pretty dreary and scientifically unrewarding. Some days are so completely dull and tasteless and full of frustration that you curse the day you ever decided to become a doctor. I often remind myself on such days of something Dr. Ben Pride said to me years ago, "Every doctor has to do things every day that he doesn't like to do." But then I say to myself, "Does it have to last all day." Still there are the golden days full of sharp diagnosis and successful treatment, all warmed by the gratitude of people you have helped.

I have said that I envy you the instruction you have had. Let me say too that I admire your courage, the gamble you were willing to take with the new unknown clinical years. You knew that your first two years were good enough to take you anywhere, as has been true for more than 25 years. But how would your second two years be, with the hospital just opening, the clinical faculty in its days of formation, half-staffed and growing? It did take confidence and courage to stay on here. May I compliment you. You have had the privilege of direct exposure to the sharpest of clinical minds, and with a degree of intimacy that your fellows who went elsewhere have not had.

If you think sometimes that there are gaps in your education, be sure that gaps exist for others everywhere. After all the medical career is one of continuing lifetime education, or should be. You will find yourselves filling in gaps 25 years from now; that is, if you are a living physician, and not just a transmitter of out-of-date practice and theory, plus the scientific and clinical offerings of the drug salesmen. You will have to keep dusting off your brains, for much of today's knowledge is tomorrow's folly, to be cast aside and forgotten. You will make many mistakes; you should learn from these, as the rest of us have from ours. We still make them, and we still learn. That's why they call it "practice," I guess, and practice never makes perfect in medicine.

Let me advise you to watch what you say about other doctors; it is so easy to condemn what seems to be folly, ignorance or downright neglect. But you weren't there, were you? What's the rest of the story? Would you have done as well? Would you have been any quicker to spot some complicated pattern unfolding? And the man you criticize—aren't there lots of things he does that you do poorly, or can't even do at all? So much trouble comes from vanity, not recognizing one's limitations, the fear of saying, "I don't know," the unwillingness to acknowledge mistakes, and the cheap criticism of others. Who gains? Not the patient. Not You.

Remember that your patient wants to be cured, and to be cured quickly, cheaply, surely and safely. He thinks that wonder drugs should work in a few hours, or there's an operation for everything. He thinks drugs should cost next to nothing and there should be no risk of deadly reactions, no relapses and no complications. No doctor can deliver all of this, but it's not a bad idea to keep these things in mind, and try. And never forget to do something for his chief complaint.

With all your preoccupations you must also cultivate the quality of mercy; kindness not just to the patient, but to all who aid in his care. The nurses, technicians, aides, orderlies and janitors all help you by doing tasks that you can't possibly do, nor perhaps could even bring yourselves to do. The goodwill of these people is of great worth to the patient, and also to you; their antagonism or ill-feeling can torpedo your best efforts.

What about money? We are in changing, rapidly changing, times throughout this country and the world. Inevitable change has already taken place in medicine, with more perhaps to follow. Most of you are not only broke, but in debt, just as most of us once were. Cheer up, don't worry, there's plenty of work to do and whatever the pattern of medicine may become, the doctor will continue to be respected and decently paid. Remember you are in a profession, not a business.

As you grow older remember yourselves as you are now; cling to your idealism, and be sure to help the young doctors who come after you, as if they were your children, and be willing to

learn from them. We are in a great enterprise together, which needs youth as well as age, temerity as well as conservatism.

So let me now, in farewell, charge you with the words of Maimonides, the great Jewish physician of the Arabic world in the times of the Crusades.

"O God, thy eternal providence has appointed me to watch over the life and health of thy creatures. May the love for my art actuate me at all times. May neither avarice nor miserliness, nor thirst for glory, nor for a great reputation engage my mind, for these enemies of truth and philanthropy could easily deceive me, and make me forgetful of my lofty aim of doing good to thy children.

"May I never see in the patient anything but a fellow creature in pain. Grant me strength, time and opportunity always to correct what I have learned, always to extend its domain, for knowledge is immense, and the spirit of man can extend infinitely to enrich itself, daily, with new learning. Today man can discover his errors of yesterday, and tomorrow he may obtain a new light on what he thinks himself sure of today.

"O God thou hast appointed me to watch over the life and death of thy creatures. Here I am ready; and now I turn to my calling."

Plans for the Care of the Aged

We must, all of us, do whatever we can to defeat the Social Security approach to medical care for the aged. We must, all of us, work in our respective states to see that every possible support is given to the implementation of the Kerr-Mills bill which is now law. The one is a piece of proposed legislation which involves compulsion and Federal control of doctor and patient. The other—the Kerr-Mills law—is a locally controlled, voluntary mechanism to help those who need the help.

We must all remember that members of Congress are not impressed by organized medicine as such. They do not react to persuasions from the American Medical Association, its Washington Office, its Council on Legislative Activities or the American Association of Railway Surgeons. Only a Congressman's constituents can cause him to act. You and your friends at home are constituents.

American medicine is struggling for its very life, and not only is medicine and the freedom to practice free medicine at stake, but the entire free enterprise system itself, is at stake. We must not be complacent. It is time for us to roll up our sleeves and work as if our very professional lives were depending on it—because they are. Let me close with a quotation by Edmund Burke, in the middle portion of the 18th century: "To assure the triumph of evil, it is only necessary that good men do nothing."—McKinnie L. Phelps, M. D., in Industrial Medicine and Surgery.

The President's Page

In Retrospect

BEING president of the West Virginia State Medical Association has been an honor, certainly an experience, but you could hardly call it fun. During the ninety-one days, either whole or in part, that I have been away from Wheeling in the past year representing our Association, I have traveled over most of our State and a large part of our country.

Many conclusions might be drawn from these experiences but the one that keeps recurring to me most often is that we can be really proud of our State, our medical facilities and the physicians practicing therein. I am firmly convinced that we would have little trouble attracting capable physicians to our midst if they could visit our State as I have during the past several months. I am positive that the West Virginia described in some of our national periodicals is not the State that I traversed so frequently.

It goes without saying that this has been a significant year for all of us. Continuous crises have welded the physicians of our state and nation into a unified force which we have never heretofore experienced. This unity we must preserve and foster because with it we will continue to contain political demagogues who would see our profession deteriorate under the yoke of Federal controls. The defeat of the King-Anderson Bill in this Congress will not be the end of such attacks. They will continue to plague us until we, as physicians, solve whatever problems that exist relative to medical care. This will require effort, thought and sacrifice on the part of each of us.

On the evening of June 26 I had the pleasure of attending the Presidential Inauguration Ceremony during which Dr. George M. Fister became the 116th President of the American Medical Association. This was by far the most impressive affair ever held at an annual meeting of the Association. Presidents of all fifty states and two territories were seated on stage during the ceremony. Following the inauguration individual state receptions, designated by state flags, were held in the Grand Ballroom of the Conrad Hilton Hotel. It was a pleasure to speak with those from West Virginia who were able to attend this function.

The very physical immensity of this annual AMA meeting defies description. A feeling of infinite smallness comes over one at these meetings that leads some members to think they are not really a part of this great organization. Nothing is farther from the truth. Each of us is to the AMA as an individual is to his community or to his Congress. I might say our wishes are reflected and our individual desires are carried out to a much greater degree in our national organization than is true in political subdivisions of which we are a part. Perhaps this can best be appreciated by attending meetings of the House of Delegates and the various Councils and Committees of the House where resolutions offered by State Societies are considered. After witnessing this democratic process, where the thoughts of each delegate and member may be heard, we are less likely to remain complacent when the American Medical Association is attacked. When this occurs the attack is against us—the individual physician—since we are the AMA.

I was pleased to see Dr. Edward R. Annis named as president elect of the American Medical Association. He has contributed so much to our fight to remain free from political domination. Without doubt, the AMA under his direction will continue to be a vital force in preserving the best medical care in the world.

Let me say in closing I shall always remember and cherish the wonderful cooperation and advice that I have received during the past year from our membership, the Council, the various committees and their chairmen, the Auxiliary and Bill Lively, Mary Hamilton, Becky Linville and lately Jerry Gould of our state office. I also would like to thank my partners, Leonard P. Hudnall, Harry S. Weeks, Jr., and Robert S. Robbins for their patience during my absences, and our surgeons for their forebearance. I hope my dear wife Dorothy, and our children will be happy just to get me back.

To my successor, Dr. L. J. Pace, I pledge my closest cooperation and my best efforts as I am sure do all of you.

I hope to see all of you at our Annual Meeting at The Greenbrier. Come early and stay late.

D. E. Greeneltch, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 343-4607.

EDITORIALS

WE'LL SEE YOU AT THE GREENBRIER

The Program Committee in charge of making arrangements for the 95th Annual Meeting later this month has been busy since the final day of the 1961 meeting at The Greenbrier. Following perusal of the convention program in this issue of *The Journal*, we are sure that you will agree that the Committee has done a magnificent job in lining up a program that will be of much interest to both general practitioners and specialists.

Dr. Halvard Wanger of Shepherdstown, the Chairman, and the other members, Drs. Charles D. Hershey of Wheeling and George P. Heffner of Charleston, have succeeded in obtaining as speakers some of the nation's most prominent physicians and surgeons.

We are delighted that our Association once again will be given the opportunity to serve as host to several physicians who have appeared as guest speakers at previous meetings at The Greenbrier. Drs. William S. Middleton, I. S. Ravdin, Stewart G. Wolf and Irving S. Wright have a legion of friends in West Virginia as a result of previous visits to White Sulphur Springs, and we know that our members and their wives will make their return visits equally as pleasant and entertaining. We also take this opportunity to extend a cordial welcome to the other guest speakers and their wives. We hope that they will enjoy their visit to this world-famous resort.

Dr. D. E. Greeneltch of Wheeling will deliver his Presidential Address at the first session of the House of Delegates on Wednesday evening, Aug-

D. E. Greeneltch, M. D.
President

ust 22, and Dr. George M. Fister of Ogden, Utah, President of the American Medical Association, will present an address at the second session of the House on Saturday afternoon, August 25.

The Presidential Dinner honoring Doctor Fister will be held on Saturday evening, August 25, and will be preceded by a reception honoring the officers of the State Medical Association. Physicians, their wives, guests and representatives of our industrial exhibitors are cordially invited to attend both the reception and dinner.

We also will be honored to have with us the Rev. Robert P. Varley, Th.D., who has traveled thousands of miles during the past year as a member of the Speaker's Bureau of the American Medical Association. He has accepted Dr. D. E. Greenelteh's invitation to appear as speaker at the Presidential Dinner.

Doctor Varley, who is Rector of St. Peter's Episcopal Church in Salisbury, Maryland, will speak on "Individual Integrity or Social Suicide." He is one of the nation's foremost spokesmen for the preservation of free enterprise in our democratic way of life. In his talks before groups in 36 states he has urged physicians and members of other professions to unite in resisting socialistic influences in the United States.

Another honor guest will be Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army. General Heaton is a native of Parkersburg and served as Commanding General of Walter Reed Army Medical Center prior to being appointed to his present post in 1959. He was awarded an honorary degree by West Virginia University during commencement exercises in Morgantown in June.

General Heaton will be the first speaker on the program arranged for Thursday morning, August 23. Members of the Auxiliary and guests have been extended a cordial invitation to hear the address by General Heaton.

The Greenbrier's new West Virginia Wing has been completed and the general scientific sessions and several of the afternoon section meetings will be held in meeting rooms in the Exhibit Center.

Completion of the new Exhibit Center will enable us to hold our scientific and business sessions in close proximity to the exhibits, which certainly are a most important part of our convention program. The usual breaks have been arranged during morning sessions so that physicians and their guests will have an opportunity to visit in the exhibit hall and talk with representatives of the firms that have booked space at our meeting.

Exhibits will be opened each morning at 8:30 to enable physicians to make an early morning round of the Exhibit Center before the scientific sessions are called to order. The scientific exhibits are of unusual interest this year and we feel it is unnecessary to remind the members of our indebtedness to the industrial exhibitors for their financial support. Also, the representatives in attendance are dedicated individuals who are interested in discussing with physicians the new products and recent therapeutic developments. We urge you to set aside several hours to visit in the exhibit hall.

The Woman's Auxiliary is in charge of the entertainment program in connection with the Annual Meeting. Mrs. Vernon L. Dyer of Petersburg, the President, has announced that the Barter Players of Abingdon, Virginia, will perform in Chesapeake Hall on Friday evening, August 24. This famous theatrical group will be brought to The Greenbrier under the sponsorship of the Potomac Valley Medical Society. Mrs. Dyer has issued a cordial invitation to those in attendance at the convention to attend this popular entertainment feature.

We hope that all of our members will take time to study the program thoroughly and plan to be with us at The Greenbrier later this month. As of this date (July 15) reservations have passed the 600 mark and we urge you to make your reservation immediately if you have not already done so.

We'll see you at The Greenbrier!

PROFESSIONAL FREEDOM

This is the time of year when your duly-elected editorial staff enters into the true spirit of dog-days and summer doldrums. They mark this period of editorial desuetude by asking for "guest" editorials from retired medical politicians who have no other hope of making the printed page.

The one subject, Medical and Health Care of the Aged, is still paramount in the minds of the public, the politicians, the professional social workers and the medical profession. From its inception as a "social welfare program" it has now degenerated into a political football, and the game's strategic moves are largely being called from the respective benches in Chicago and Washington.

The proponents of ultimate compulsory medical care have shown determination and dedication, sometimes combined in the individual or group, in their all-out efforts. Organized medi-

cine has in large part demonstrated an equal degree of determination in its forensic and political activities, but there are still too many physicians who are loath to assume the role of active political participants in a matter which is so vital to our future. This is not a time to let George do all the work.

It is all very well and very essential that political education of our people be carried out in all areas of public communication, but the final outcome will be determined by the wishes of the majority of voters—the very same persons with whom every physician enjoys such intimate contacts in the office, home and hospital. One word of advice from physician to patient in this environment is worth a hundred words published or spoken over radio and television, or before a civic club.

We need no longer look across the Atlantic for examples of what compulsory medical care can produce; just cast your eyes in a northwesterly direction across the Canadian border. In that area a group of professional victims of state welfare medicine are reportedly leading the fight against socialization in their adopted home province. The press is full of instances of alleged professional neglect, with fatalities quoted in great detail, but very little is published about the right to struggle against loss of professional freedom. In no way do we condone any departure from our moral responsibilities as physicians, but there must be some way in which we can assert our long-established rights to professional freedom.

The Congress is now struggling in an effort to produce acceptable health care legislation, with pressures exerted from many quarters. This seems a good time to get in a plug for what we have long contended to be a vital and necessary factor in providing adequate care to our older citizens. This contention is based upon the premise of "contribution according to means" by beneficiaries toward the costs of prepaid insurance. Such a plan was sent to the chairman of the House Ways and Means Committee many weeks ago, and was introduced as a Senate amendment by Senator Morton of Kentucky. Like so many of your "guest" editors' plans and ideas, this suggestion was kicked to death by the occupants of the Senate manger.

We believe that Council and the House of Delegates should earnestly consider the advisability of active political participation by every component society and by every member in the political campaign this fall. As citizens we have the right, and as physicians who cherish professional freedom, we have the responsibility of making our votes, and those we can influence, known to both political friend and enemy.

Let every single physician keep on working, and talking, to individuals or groups, until this political issue has been decided. If we succeed in retaining our cherished ideals of practice, let us be determined to deserve these privileges. If we lose, even temporarily, let us do nothing which is in conflict with the accepted moral and ethical concepts of our professional responsibilities.—*Guest Editorial by James S. Klumpp, M. D., Chairman, Medical Economics Committee, West Virginia State Medical Association.*

RESOLUTION OF SYMPATHY

A meeting of the Board of Directors and the Advisory and Advertising Committees of the State Medical Journal Advertising Bureau was held at the Palmer House in Chicago on June 24, 1962. The following Resolution of Sympathy on the death of Dr. Walter E. Vest of Huntington, prepared by Dr. Stanley B. Weld of Hartford, Connecticut, Chairman of the Advertising Committee, was adopted during the meeting:

WHEREAS, God in His infinite wisdom on January 28, 1962, removed from our midst Walter E. Vest, M. D., and,

WHEREAS, Doctor Vest, in addition to his many commitments and interests on behalf of his patients and of the West Virginia State Medical Association, had contributed unstintingly of his time over a period of more than twenty years on behalf of the State Medical Journal Advertising Bureau and its predecessor, the Cooperative Medical Advertising Bureau; and,

WHEREAS, Doctor Vest possessed those qualities which resulted in establishing him as a leader in his profession, viz., integrity, sincerity of purpose, unselfishness, friendliness and an intellectual capacity of the highest order: therefore,

BE IT RESOLVED, That the Officers and Directors of the State Medical Journal Advertising Bureau hereby express their deep sense of loss at the death of Doctor Vest; and further;

BE IT RESOLVED, That these same Officers and Directors do hereby recognize the inestimable contributions of Doctor Vest to this Bureau as well as to the entire medical profession of the United States.

The resolution was signed by Alfred J. Jackson, President, and the members of the Board of Directors.

GENERAL NEWS

Outstanding Program Arranged For Convention, Aug. 23-25

Dr. George M. Fister of Ogden, Utah, President of the American Medical Association, heads a long list of prominent physicians and surgeons who will appear on the program at the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25.

George M. Fister, M. D.
AMA President

Doctor Fister, who is a prominent urologist, was elevated to the presidency of the AMA at the Annual Meeting in Chicago in June. He is a past president of the Utah State Medical Association and served for several years as a Delegate to the AMA House of Delegates. He also served as Chairman of the AMA Council on Legislative Activities and was a member of the Board of Trustees before being named President Elect at the 1961 meeting in New York City.

He will be the guest speaker before the second session of the House of Delegates on Saturday afternoon, August 25. His address will be heard shortly after the House convenes at three o'clock.

Another honor guest will be Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army. General Heaton, who is a native of Parkersburg, will deliver an address at the first general scientific session on Thursday morning, August 23. His subject will be "The Role of Army Medical Research in National Defense."

More than 800 persons, including physicians, their wives and guests are expected to attend the three-day meeting at White Sulphur Springs.

Presidential Dinner on Saturday Evening

Dr. D. E. Greeneltch of Wheeling, President of the State Medical Association, announced last month that the Rev. Robert P. Varley, Th.D., had accepted his invitation to appear as speaker at the Presidential Dinner honoring Doctor Fister in Chesapeake Hall on Saturday evening, August 25.

Doctor Varley, who is Rector of St. Peter's Episcopal Church in Salisbury, Maryland, is a member of the Speaker's Bureau of the American Medical Association and has traveled more than 75,000 miles during the past year giving talks before groups in 36 states.

He is one of the nation's foremost spokesmen against socialistic influences in the United States. His subject will be "Individual Integrity or Social Suicide."

A cocktail party and reception honoring officers of the West Virginia State Medical Association will be held on the Chesapeake Hall Terrace preceding the Dinner.

Tickets for the Presidential Dinner will be placed on sale in the registration area, beginning on Wednesday afternoon, August 22.

Pre-Convention Meetings

The convention will not be formally opened until Thursday morning, August 23; however, several important committee meetings have been scheduled for Wednesday afternoon, August 22, and the pre-convention meeting of the Council will be held at four o'clock.

The registration desk will be open from 2:30 to 4:30 o'clock on Wednesday afternoon, and from 8:30 to 9:30 that evening. The desk will be open on the main floor lobby from 8:30 A. M. to 5:00 P. M. daily thereafter during the convention.

Presidential Address by Dr. D. E. Greeneltch

Dr. D. E. Greeneltch of Wheeling will deliver his Presidential Address at the first session of the House of Delegates which will be held in Chesapeake Hall on

Wednesday evening, August 22, at nine o'clock. He will preside at the business session which will follow his address.

Scientific Sessions in New Wing

The three general scientific sessions will be held in Governor's Hall in the new West Virginia Wing. Several of the afternoon meetings of sections and affiliated societies also will be held in Governor's Hall and the Mountaineer Room in the new Wing.

The industrial and scientific exhibits will be housed in the beautiful and spacious Exhibit Center in the West Virginia Wing.

Motion Pictures

Sound motion pictures on appropriate scientific subjects will be shown on Thursday, Friday and Saturday mornings prior to the opening of each general scientific session. The chairman of the committee arranging the motion picture program during the meeting is Dr. Ralph H. Nestmann of Charleston. The pictures will be shown in Governor's Hall.

Formal Opening of Convention Thursday Morning

The convention will be called to order by Dr. Halvard Wanger of Shepherdstown, Chairman of the Program Committee, on Thursday morning, August 23, at nine o'clock. The address of welcome will be delivered by Dr. D. E. Greeneltch of Wheeling, President of the State Medical Association.

The first speaker on the program will be Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army, whose subject will be "The Role of Army Medical Research in National Defense."

The meeting will then be turned over to Dr. Charles D. Hershey of Wheeling, who will serve as moderator for the first general session. The guest speakers and their subjects are as follows:

I. S. Ravdin, M. D., Professor of Surgery and Vice President of Medical Affairs, University of Pennsylvania, Philadelphia. Subject: "Cancer Chemotherapy."

A. Edward Maumenee, M. D., Professor of Ophthalmology, Johns Hopkins University School of Medicine, Baltimore. Subject: "Ocular Manifestations of General Medical Disease."

Otto C. Phillips, M. D., Professor of Anesthesiology, University of Pittsburgh School of Medicine, Pittsburgh. Subject: "Factors in Obstetrical Mortality: The Role of Anesthesia."

Thursday Afternoon Program

Dr. A. C. Esposito of Huntington will preside at a meeting of the Resolutions Committee which will be held at two o'clock on Thursday afternoon.

An open meeting of the West Virginia State Society of Allergy will be held at two o'clock. Dr. M. D. Reiter of Wheeling, President of the Society, will deliver an address of welcome and the moderator for the scientific session will be Dr. Merle S. Scherr of Charleston.

L. J. Pace, M. D.
President Elect

The guest speakers and their subjects are as follows:

William A. Hopkins, M. D., Atlanta, Georgia. Subject: "Chronic Lung Disease: Group and Clinic Therapy."

Gustav J. Beck, M. D., New York City. Subject: "Physiologic Considerations in the Management of Bronchial Asthma and Pulmonary Emphysema."

Irving W. Schiller, M. D., Boston. Subject: "A Brief Review of Drug Therapy in Bronchial Asthma."

There will be a panel discussion and question and answer period following presentation of the papers.

Dr. I. S. Ravdin of Philadelphia will present a paper on "Cancer of the Large Bowel" before the Section on Surgery at two o'clock. Dr. A. Kyle Bush of Philippi will preside.

Daywood Art Gallery In Lewisburg

Physicians, their wives and guests attending the annual meeting at The Greenbrier in August have been extended a cordial invitation to visit the Daywood Art Gallery in nearby Lewisburg. The Gallery is open daily, except Sunday, from 1:00-5:00 P. M. Admission is free.

Thousands of visitors from this country and abroad have visited the Gallery since its opening in 1951. It was established by Ruth Woods Dayton in memory of her husband Arthur Spencer Dayton, an attorney and collector of art and rare books.

Exhibited in a homelike atmosphere of English and American antique furnishings are 75 paintings and 145 etchings by nationally recognized artists.

Dr. George F. Fordham of Mullens will preside at a meeting of the Section on Industrial Medicine and Public Health which will be held at two o'clock.

MCV Alumni Party

The West Virginia Chapter of the Medical College of Virginia Alumni Association will hold a cocktail party on Thursday evening at 6:30 o'clock. Dr. Carl B. Hall of Charleston is in charge of arrangements.

Second General Session
Friday Morning

Dr. Thomas H. McGavack of Martinsburg will serve as moderator for the second general session beginning

Lt. Gen. Leonard D. Heaton

at 9:30 o'clock on Friday morning, August 24. The guest speakers and their subjects are as follows:

Stewart G. Wolf, M. D., Professor and Head, Department of Medicine, University of Oklahoma School of Medicine, Oklahoma City. Subject: "The Relation of Life Stress to Serum Lipids in Patients with Coronary Artery Disease."

William S. Middleton, M. D., Chief Medical Director, Veterans Administration, Washington, D. C., and Dean Emeritus and Professor of Medicine Emeritus, University of Wisconsin Medical School. Subject: "Abdominal Angina."

Irving S. Wright, M. D., Professor of Clinical Medicine, Cornell University Medical College, New York City. Subject: "The Modern Treatment of Cerebrovascular Disease."

Friday Afternoon Program

Three guest speakers will appear on the program before a meeting of the Section on Internal Medicine which will be held on Friday afternoon, beginning at two o'clock. Dr. Richard V. Lynch, Jr., of Clarksburg, will preside and the speakers and their subjects are as follows:

Irving S. Wright, M. D., New York City. Subject: "Anticoagulant Therapy: A Matter for Discrimination."

Stewart G. Wolf, M. D., Oklahoma City. Subject: "A Critical Appraisal of Therapy with Notes on the Action of Placebos."

William S. Middleton, M. D., Washington, D. C. Subject: "Collagen Diseases Revisited."

A business meeting will follow the scientific program.

Dr. George M. Fister of Ogden, Utah, President of the American Medical Association, will present a paper on "Colloids of the Human Urine" before the Section on Urology at two o'clock. Dr. Thomas B. Baer of Bluefield will preside.

Dr. A. C. Esposito of Huntington will preside at a meeting of the West Virginia Academy of Ophthalmology and Otolaryngology which will be held at two o'clock. The speaker will be Dr. A. Edward Maumenee of Baltimore, whose subject will be "The Management of Glaucoma and Glaucoma Surgery."

Dr. Hugh L. Sulfridge, Jr., of Saginaw, Michigan, will present a paper on "Manipulative Treatment of Spinal Disorders" before the Section on Orthopedic Surgery at two o'clock. Dr. Earl A. McCowen of South Charleston will preside.

"Management of Endometriosis" is the subject of a paper which Dr. H. L. Riva of Jersey City will present before a meeting of the West Virginia Obstetrical and Gynecological Society which will be held at two o'clock. Dr. John T. Chambers of Charleston will preside.

Dr. Hubert A. Shaffer of Morgantown will preside at a meeting of the West Virginia Radiological Society at two o'clock. The guest speaker will be Dr. John W. Hope of Philadelphia, whose subject will be "Intestinal Obstruction in the Newborn."

Dr. James G. Hughes of Memphis will present a paper on "Behavioral Problems in Children" before a meeting of the West Virginia Pediatric Society which will be held at 3:30 o'clock. Dr. Grover C. Hedrick, Jr., of Beckley will preside.

The 1962 Program Committee

Dr. Halvard Wanger of Shepherdstown is the chairman of the Program Committee for the 95th Annual Meeting of the West Virginia State Medical Association. Other members are Drs. George P. Heffner of Charleston and Charles D. Hershey of Wheeling. They were appointed by the president, Dr. D. E. Greeneltch of Wheeling.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Surphur Springs, August 23-25, 1962.

Annual Meeting on E. S. T.

The Greenbrier, at White Sulphur Springs, operates throughout the year on Eastern Standard Time, and EST will therefore be observed strictly in the schedule of all events in connection with the annual meeting of the West Virginia State Medical Association there, August 23-25, 1962.

Dr. Thomas J. Holbrook of Huntington will preside at a meeting of the Section on Neurology, Neurosurgery and Psychiatry which will be held at four o'clock. The guest speaker will be Dr. Stewart G. Wolf of Oklahoma City, whose subject will be "Neural Mechanisms in Systemic Disease."

Dr. J. C. Huffman of Buckhannon will preside at a meeting of the Nominating Committee which will be held at five o'clock.

Third General Session Saturday Morning

Dr. George P. Heffner of Charleston will serve as moderator at the third and final general scientific session beginning at 9:30 o'clock on Saturday morning, August 25. The guest speakers and their subjects follow:

James G. Hughes, M. D., Professor and Head of the Division of Pediatrics, University of Tennessee College of Medicine, Memphis. Subject: "Epilepsy in Children."

John W. Hope, M. D., Director, Department of Radiology, The Children's Hospital of Philadelphia. Subject: "Roentgen Facts and Fallacies Regarding the Chest of Infants and Children."

H. L. Riva, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, Seton Hall College of Medicine, Jersey City. Subject: "Preventive Medical Measures in Obstetrics and Gynecology."

Saturday Afternoon Meetings

Dr. Otto C. Phillips of Pittsburgh will present a paper on "Complications of Spinal Anesthesia—Prophylaxis and Management" before a meeting of the West Virginia Society of Anesthesiologists at one o'clock on Saturday afternoon. Dr. Harry S. Weeks, Jr., of Wheeling will preside.

Dr. David B. Thornburgh of Parkersburg will preside at a business meeting of the West Virginia Association of Pathologists which will be held at 1:30 o'clock.

House of Delegates To Meet Twice During Meeting

The Program Committee has announced that there will be two sessions of the House of Delegates during the Annual Meeting at The Greenbrier.

The first session will be convened at 9:00 o'clock on Wednesday evening, August 22, and the second session is scheduled for 3:00 o'clock on Saturday afternoon, August 25.

Second Session of House of Delegates

Dr. D. E. Greeneltch of Wheeling, the President, will preside at the second and final session of the House of Delegates which will be convened at three o'clock on Saturday afternoon.

Dr. L. J. Pace of Princeton, the President Elect, will be installed as President during the business session. Other officers for 1962-63 also will be elected and installed.

Dr. George M. Fister of Ogden, Utah, President of the American Medical Association, will be the guest speaker at this session of the House.

The Rev. Robert P. Varley, Th. D.

Dr. Byron W. Steele of Mullens, who was named as West Virginia's "General Practitioner of the Year," will be introduced, together with Paul Brooks of Sissonville and Paul E. Lanham of Charleston, the recipients of the State Medical Association's 1962 four-year scholarships to the West Virginia University School of Medicine.

Friday Evening Entertainment

The Woman's Auxiliary to the State Medical Association is in charge of the entertainment program at the Convention. The feature will be a performance by the Barter Players of Abingdon, Virginia, on Friday evening, August 24, at nine o'clock.

The appearance of this famous theatrical group will be sponsored through the courtesy of the Potomac Valley Medical Society.

Cocktail Party and Presidential Dinner

A cocktail party and reception honoring the officers of the West Virginia State Medical Association will be held on the Chesapeake Hall Terrace on Saturday

evening, August 25, from 6:30 to 7:30 o'clock, and will be followed immediately by the Presidential Dinner.

All members of the Association and Auxiliary, their families, representatives of the industrial exhibitors and guests are invited to attend.

Industrial and Scientific Exhibits

More than 50 interesting and informative industrial and scientific exhibits will be housed in the spacious Exhibit Center in the new West Virginia Wing.

The exhibits will be open daily from 8:30 A. M. to 5 P. M. Physicians, members of the Auxiliary and guests are invited to visit and talk with the representatives of various drug and accessory houses who will be present throughout the meeting.

Medical and Surgical Symposium In Clarksburg on Sept. 9

A Medical and Surgical Symposium, co-sponsored by the West Virginia Chapter of the American Academy of General Practice and Lederle Laboratories, will be held at the Stonewall Jackson Hotel in Clarksburg on September 9.

A cordial invitation to attend the one-day meeting has been extended to all physicians in West Virginia. The registration desk will open at 9 A. M. and the meeting will be called to order promptly at 10 A. M.

Four prominent physicians and surgeons have accepted invitations to appear as guest speakers at the morning and afternoon scientific sessions. The speakers and their subjects at the morning session will be as follows:

"Repair of Hernia."—Jacob A. Glassman, M. D., Assistant Professor of Surgery, University of Miami School of Medicine, Miami Beach, Florida.

"Disease and Surgery of the Pancreas."—Kenneth W. Warren, M. D., Lahey Clinic, Boston, Massachusetts.

The speakers and their subjects at the afternoon session will be as follows:

"Pediatric Office Practice."—Edward V. Turner, M. D., Ohio State University College of Medicine, Columbus.

"Pheochromocytoma."—Samuel Tisherman, M. D., Pittsburgh, Pennsylvania.

Dr. Joseph Gilman of Clarksburg, Chairman of the Program Committee, said that there will be panel discussions following the two sessions. He also announced that a luncheon will be served to all physicians and their wives in attendance, and that there will be a reception at the conclusion of the afternoon session.

Further information concerning the program may be obtained by writing Doctor Gilman, 535 Empire Bank Building, Clarksburg, West Virginia.

New Fellows of ACP

Drs. Ralph H. Nestmann, Philip Preiser and Willard Pushkin, all of Charleston, were inducted as Fellows of the American College of Medicine during the recent annual meeting in Philadephia.

Nominating Committee To Meet On Friday, Aug. 24

The Committee on Nominations of the State Medical Association will meet at five o'clock on Friday afternoon, August 24, during the Annual Meeting at The Greenbrier. The Committee was created as a result of the adoption of an amendment to the By-Laws during the 1961 Annual Meeting.

The Committee will consider and recommend to the House of Delegates prior to the election of officers, at its final session, its nominee for the office of president elect, vice president, treasurer and the American Medical Association delegate and alternate.

The current councillor at large, Dr. J. C. Huffman of Buckhannon, will serve as chairman and the other members are the following senior councillors in point of service from each councillor district: Drs. Richard E. Flood of Weirton, S. Elizabeth McFetridge of Shepherdstown, Richard V. Lynch, Jr., of Clarksburg, A. C. Esposito of Huntington, Harold Van Hoose of Man, and Clyde A. Smith of Beckley.

The By-Laws also specify that nominations may be made from the floor for the above-mentioned offices.

ACP Regional Meeting Planned At The Greenbrier, Nov. 2-3

The president of the American College of Physicians will be among the guest speakers at a regional meeting of that organization which will be held at The Greenbrier in White Sulphur Springs, November 2-3, 1962.

Dr. Franklin M. Hanger of Staunton, Virginia, who was installed as president of the ACP at the Annual Meeting in Philadelphia in April, will be the speaker at a banquet which will be held on Friday evening, November 2.

Dr. R. U. Drinkard of Wheeling, Governor of the West Virginia Chapter, ACP, announced that physicians from West Virginia, Western Pennsylvania and Ohio will attend the two-day meeting.

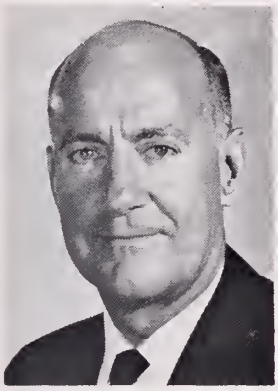
Doctor Drinkard said a meeting for members of the American Society of Internal Medicine from these three states will be held in conjunction with the regional meeting.

The Chairman of the Program Committee is Dr. Edmund B. Flink of Morgantown, Professor and Head of the Department of Medicine at the WVU School of Medicine. Dr. Arnold J. Brody of White Sulphur Springs is chairman of the Committee on Arrangements. Room accommodations may be obtained by writing to the Reservation Manager at The Greenbrier.

Further information concerning the scientific program will appear in future issues of *The Journal.*

Dr. Edward R. Annis Named AMA President Elect

Dr. Edward R. Annis of Miami, Florida, was named President Elect of the American Medical Association at the annual meeting in Chicago, June 24-28. He was elected by the House of Delegates at the concluding session at the Palmer House on June 28.



Edward R. Annis, M. D.

Doctor Annis, who is Chairman of the AMA National Speakers Bureau and foremost spokesman in the campaign against the King-Anderson bill, will be installed as President at the 1963 annual meeting in Atlantic City. He will succeed Dr. George M. Fister of Ogden, Utah, who assumed office during the meeting in Chicago.

Dr. J. P. Culpepper, Jr., of Hattiesburg, Mississippi, was elected vice president, and Drs. Norman A. Welch of Boston and Milford O. Rouse of Dallas, were reelected speaker and vice speaker of the House of Delegates, respectively.

Reelected to five-year terms on the Board of Trustees were Drs. Wesley W. Hall of Reno, Nevada, and Charles L. Hudson of Cleveland.

Dr. Walter E. Bornemeier of Chicago was reelected a member of the Council on Constitution and By-Laws, and Dr. James M. Kolb of Clarksville, Arkansas, was named to fill the unexpired term of the late Dr. Walter E. Vest of Huntington.

Dr. Elmer G. Shelley of North East, Pennsylvania, was renamed to the Judicial Council, and Drs. Warde B. Allan of Baltimore and W. Clarke Wescoe of Lawrence, Kansas, were reelected to the Council on Medical Education and Hospitals.

Dr. George W. Slagle of Battle Creek, Michigan, was elected to the Council on Medical Service, succeeding Dr. Robert L. Novy of Detroit.

State Delegates Attend Meeting

Drs. Charles A. Hoffman of Huntington and Frank J. Holroyd of Princeton, AMA Delegates, attended the meeting in Chicago. Doctor Holroyd served as a member of the Reference Committee on Reports of Officers.

Officers of the State Medical Association present were Dr. D. E. Greeneltch of Wheeling, President; and Dr. Charles L. Goodhand of Parkersburg, Vice President.

Registration and Future Meetings

Total registration at the four-day meeting was 42,643, including 14,092 physicians.

The 1962 Clinical Meeting of the AMA will be held in Los Angeles, November 25-29. Other meetings are scheduled as follows: 1963 Annual Meeting, Atlantic City; 1963 Clinical Meeting, Portland, Oregon; 1964 Annual Meeting, San Francisco; 1965 Annual Meeting, New York City; 1965 Clinical Meeting, Philadelphia; 1966 Annual Meeting, Chicago; 1966 Clinical Meeting, Las Vegas; 1967 Annual Meeting, Atlantic City; and 1968 Annual Meeting, San Francisco.

Summary of Chicago Meeting

The following summary of the Chicago meeting was prepared for publication by Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association:

Health care for the aged, medical discipline, composition of the AMA Board of Trustees, a study of the American Board of Abdominal Surgery, relations with the American College of Surgeons and voluntary health insurance were among the major subjects acted upon by the House of Delegates at the 111th annual meeting of the American Medical Association in Chicago, June 24-28.

The AMA 1962 Distinguished Service Award was voted to Dr. Russell L. Cecil of New York City, senior editor of the *Textbook of Medicine* and one of the nation's leading researchers in the field of arthritis.

Health Care for the Aged

The House received 17 resolutions expressing full support of the Kerr-Mills program and firm opposition to King-Anderson type legislation. In reaffirming the position of active opposition to the King-Anderson Bill, the House cited the following reasons:

(1) the lack of the need for such a plan, (2) that it would provide inadequate care for all aged rather than complete care for those who need help, (3) the fact that inherent in the use of the Social Security mechanism are governmental controls of medical practice which would increase with the expansion of the program, and (4) deterioration of the quality of medical care not only for the aged but for the population as a whole.

In reaffirming strong support for the Kerr-Mills Law, the House declared that "the Kerr-Mills method should be given a fair and reasonable chance to meet the need and thus remove the demand for further Federal legislation."

It urged that in states where existing programs indicate a need for a Kerr-Mills implementing law, each state association should actively sponsor and promote with other responsible citizens the enactment of such a law. It also urged the state associations to "work actively with other responsible citizens in reviewing the functions of the law, evaluating its effectiveness and aggressively supporting improvements in programs to aid those aged who need help so as to achieve the provision of quality medical care and service."

The House took no action on one resolution which called for non-participation in the implementation of the King-Anderson Bill, but it urged individual physicians to give particular consideration to the following sections of the Principles of Medical Ethics:

"Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioriation of the quality of medical care."

Commenting on the Association's fight against the King-Anderson Bill, Dr. Leonard W. Larson, retiring president, told the opening session of the House that "this great struggle has been testing again whether the science and art of medicine will be permitted to grow and flourish in freedom, or whether progress in medicine will be stunted and shriveled by the excesses of government control."

He declared that the steadfast refusal of the AMA to compromise on basic principles "has been a source of strength for us and our friends." Doctor Larson expressed confidence in ultimate victory, but he added that victory will impose a solemn obligation of responsible leadership for all physicians.

Also commenting on the question of compromise, Doctor Fister in his inaugural address said "we will not compromise with those who regard medical care problems as simply playthings in the game of politics—gimmicks to attract the votes of the gullible."

Medical Discipline

To implement one of the major recommendations made by the Medical Disciplinary Committee at the June, 1961, meeting in New York City, the House approved a change in the By-Laws under which a proposed Section 1 (B) of Chapter IV will now read:

"In addition to such disciplinary action as may be taken under the constitution and by-laws of the component society and constituent association to which the Member belongs, or when a state medical association to which a Member belongs requests the AMA to take disciplinary action, or when at the request of the American Medical Association the state association to which the member belongs consents to disciplinary proceedings by AMA, the Judicial Council, after due notice and hearing, may censure him, or may suspend or expel any member of the American Medical Association from AMA membership only for an infraction of the Constitution or these By-laws or for a violation of the Principles of Medical Ethics."

AMA Board of Trustees

The House approved a report of the Ad Hoc Committee on the Board of Trustees which recommended that the size of the Board be increased from 11 members to 15 members. This will be accomplished by adding three elected members and by including the immediate past president of the Association for a one-year term. The House also accepted a committee recommendation that set the term of office for elected Board members at three years and limited the number of terms to three, for a maximum total of nine years service. To implement the House action, the Council on Constitution and By-laws submitted changes in the Constitution and By-laws for consideration at the 1962 Clinical Meeting.

American Board of Abdominal Surgery

A study report from the Council on Medical Education and Hospitals, recommending that recognition should not be granted to the American Board of Abdominal Surgery as a specialty board, was approved by the House. In accepting the Council report, the

Dr. D. E. Greeneltch of Wheeling, President of the State Medical Association, participated actively in the inauguration of Dr. George M. Fister as President of the American Medical Association at the AMA's 111th annual meeting in June at Chicago. Dr. and Mrs. Greeneltch are shown in the receiving line at the reception which followed the ceremony.

House also declared its disapproval in principle of establishing specialties which are based largely or wholly on an arbitrarily defined anatomical region of the body.

The study, which was carried out under instructions from the House of Delegates at the 1961 Clinical Meeting, concluded that the present contribution of the American Board of Abdominal surgery to the advancement of surgery and the betterment of public health is inadequate in many important respects. It also concluded that the American Board of Abdominal Surgery does not offer significant potential for the advancement of surgery and the betterment of public health.

American College of Surgeons

In considering a Board report and four resolutions involving surgical assistants and relations between the AMA and the American College of Surgeons, the House declared that the adoption and interpretation of the Principles of Medical Ethics is the prerogative and duty of the American Medical Association. It also restated the Association's June, 1961, policy statement in the following manner:

"(1) Each member of the AMA is expected to observe the Principles of Medical Ethics in every aspect of his professional practice.

"(2) Each doctor engaged in the care of the patient is entitled to compensation commensurate with the value of the services he has personally rendered.

"(3) No doctor should bill or be paid for a service which he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received.

"(4) When services are rendered by more than one physician, each physician should submit his own bill to the patient and be compensated separately whenever possible.

"(5) It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist him in the performance of a surgical procedure and to pay a reasonable amount for such assistance. This principle applies whether or not an assisting physician is the referring doctor."

Voluntary Health Insurance

In accepting a Council on Medical Services report on the utilization of state and federal tax funds to provide voluntary prepayment health insurance protection to assist the aged in meeting the costs of health care services, the House approved the following policy statement:

"1. The need for application of the prepayment or insurance principle to protect our people against the costs of medical care is fully recognized and applies to all ages rather than to the aged alone.

"2. Persons financially able to prepay their own expenses are expected to do so and must be encouraged rather than compelled to do so.

"3. Persons financially unable to prepay adequately their expenses may properly be assisted to the degree necessary by their families, their communities, their states, and if these fail, by the Federal Government—but only in conjunction with other levels of government.

"4. The prepayment system should be devoid of government controls.

"5. Dignity and self-sufficiency for the individual should be upheld.

"6. The protection offered must be reasonably comprehensive rather than token in character."

The House recommended that the Board of Trustees and the Council on Medical Service explore all possibilities, using these principles as a basis.

Miscellaneous Actions

In considering reports and resolutions on a wide variety of subjects, the House also:

Learned that the Board of Trustees has instructed the Council on Drugs to conduct a study on the relationship between tobacco and disease.

Disapproved a suggestion that the Council on Medical Education and Hospitals be replaced by two separate councils on undergraduate and graduate medical education.

Referred to the Board of Trustees a proposal that at least six members of the Council on Medical Education and Hospitals shall be engaged primarily in the private practice of medicine in hospitals without a medical school affiliation and that no more than four members may be salaried personnel of a medical school or university.

Approved a resolution that honorariums be provided for the Association's elected officers in amounts to be determined by the Board of Trustees.

Adopted an AMA Statement of Principles on Mental Health and urged all constituent associations to lend active support to the First National Congress for Mental Illness and Health, to be held in Chicago in October.

Endorsed a resolution on employment of the handicapped, stating that each individual candidate for employment should be evaluated in light of his ability to perform useful work.

Approved a Guide to the Organization and Operation of Airport Medical Services submitted by the Council on Occupational Health.

Endorsed the joint statement on narcotic addiction by the AMA and the National Research Council of the National Academy of Sciences.

Urged automobile manufacturers to make seat belts, approved by the Society of Automotive Engineers, standard equipment on all automobiles.

Recommended that the Council on Medical Education and Hospitals conduct a study of specialty residencies.

Reaffirmed its opposition to compulsory coverage of physicians under the Social Security Act, after receiving 11 resolutions opposing coverage and only two favoring the inclusion of physicians.

Accepted the report of the Committee on Communications as information, and, in considering the committee recommendations, suggested that the Executive Vice President present a report of Association activities to the House at each meeting.

Opening Session

At the Monday morning session, the AMA presented a special citation to Jackie Cooper, star of television, stage and movies, for his portrayal of a Navy doctor in the "Hennessey" television program. The 1962 Joseph Goldberger Award in clinical nutrition was presented to Dr. Edwards Albert Park of Baltimore for his investigations of rickets and scurvy in children. Doctor Larson received a plaque for his work on the medical advisory board of the Sears-Roebuck Foundation. The American Medical Association was given awards of appreciation from the Cuban Medical Association in Exile and the Girl Scouts of America.

Inaugural Ceremony

Doctor Fister, in his inaugural address, declared that "we will cooperate, to our very utmost, with government officials, legislators and all Americans who are sincerely interested in finding sound, practical solutions to medical care problems—solutions which include both a respect for medical standards and a respect for the taxpayers."

Wednesday Session

Doctor Fister, in his Wednesday address, assured the House of Delegates, all AMA members and the citizens of this country that "during the next year there will be no letup in our campaign to preserve the high standards of our voluntary, free choice, medical care system."

Dr. Thornhill Named Vice President Of Therapeutic Society

Dr. William A. Thornhill, Jr., of Charleston, was elected Vice President of the American Therapeutic Society during the 63rd annual meeting of that organization which was held at the Sheraton - Blackstone Hotel in Chicago, June 21-24.

Wm. A. Thornhill, Jr., M. D.

Doctor Thornhill has been active for many years in the Society which is composed of more than 350 members. He is a native of Lawton, West Virginia, and was graduated from West Virginia University. He attended the two-year School of Medicine at the University and received his M. D. degree in 1934 from Cornell University Medical College. He served his internship at Temple University Hospital in Philadelphia. His specialty is internal medicine.

Doctor Thornhill has practiced in Charleston since 1936 and he served a term as secretary-treasurer of the Kanawha Medical Society. He served with the Medical Corps of the United States Navy during World War II and was discharged with the rank of Commander in 1945.

Dr. Elbert L. Persons of Durham, North Carolina, was installed as president of the Society, succeeding Dr. George C. Griffith of Los Angeles. Dr. L. Clagett Beck of Honolulu, Hawaii, was named president elect and Drs. William J. Grace of New York City, and George H. Reifenstein of San Francisco also were named vice presidents.

Doctor Beck will be the third member of a prominent family in medicine to serve as president of the organization. His grandfather, Dr. Carl Beck of New York City, served as president, 1904-5, and his father, Dr. Harvey G. Beck of Baltimore, was named president in 1931.

Medical Meetings, 1962

The following is a partial list of national, state and district medical meetings scheduled for 1962:

Aug. 16-18—W. Va. Hospital Assn., White Sul. Springs.
Aug. 23-25—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 9-15—Dermatology Congress, Washington.
Sept. 13-16—PG Institute, Martinsburg.
Sept. 17-20—American Hospital Assn., Chicago.
Sept. 20-21—W. Va. Heart Assn., Morgantown.
Oct. 1-4—Interstate PG Assembly, Chicago.
Oct. 4-6—Congress on Mental Illness, Chicago.
Oct. 9-11—W. Va. TB and Health Assn., Beckley.
Oct. 15-19—ACS Clinical Congress, Atlantic City.
Oct. 22-23—American Cancer Soc., New York.
Nov. 2-4—ACP Regional Meeting, White Sul. Springs.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 24-25—ACCP, Ambassador Hotel, Los Angeles.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.

Mrs. Stoltz Named President Elect Of AMA Auxiliary

Mrs. Vernon L. Dyer of Petersburg, President of the Woman's Auxiliary to the West Virginia State Medical Association, and Mrs. Howard G. Weiler of Wheeling, the president elect, were among West Virginians who attended the 39th annual meeting of the Woman's Auxiliary to the American Medical Association in Chicago, June 24-28.

Mrs. William G. Thuss of Birmingham, Alabama, was installed as president of the organization, succeeding Mrs. Harlan English of Danville, Illinois. Other new officers are as follows:

Mrs. C. Rodney Stoltz of Watertown, South Dakota, president elect; Mrs. Harry F. Pohlmann of Middletown, New York, first vice-president; Mesdames Morton Arnold of Windham Center, Connecticut, Richard A. Sutter of St. Louis, Missouri, Robert D. Croom, Jr., of Maxton, North Carolina, and Mrs. G. Prentiss Lee of Portland, Oregon, regional vice-presidents; Mrs. William H. Evans of Youngstown, Ohio, constitutional secretary, and Mrs. C. R. Pearson of Baraboo, Wisconsin, treasurer.

In her inaugural address, Mrs. Thuss said physicians' wives must broaden the scope of their education and understanding if they are to realize the satisfaction of meeting responsibilities to families, to communities and to the future.

Mrs. Thuss urged that members support medical education, promotion of safety education for all age groups, mental health, physical fitness programs in schools, campaigns against quackery, recruitment of outstanding young people into medical careers, rural health and international health activities.

A check for $244,172.00 was presented by the Auxiliary to the AMA Educational and Research Foundation for the nation's 86 medical schools at a luncheon honoring national past presidents.

The speaker at a luncheon meeting held on Tuesday, June 26, was Dr. Leonard W. Larson of Bismarck, North Dakota, immediate past president of the American Medical Association. He praised physicians' wives for their work in "fighting to preserve the finest form of medicine in the world today."

In another address, Dr. Edward R. Annis of Miami, Florida, president elect of the American Medical Association, said it was up to every doctor's wife to remind her husband that he, as a citizen, has a personal responsibility to spread the true facts about the profession. The Constitution, he said, guaranteed the pursuit of happiness, "but you have to catch up with it yourself and not leave the job to someone else."

Doctor Holroyd Reappointed to MLB

Dr. Frank J. Holroyd of Princeton has been reappointed by Governor W. W. Barron as a member of the Medical Licensing Board of West Vrginia for the five-year term ending June 30, 1967.

Doctor Holroyd was named a member of the Board in 1949 and has been its Chairman since July, 1953.

Possibility of Polio Epidemic Still Exists in State

The possibility of a polio epidemic in West Virginia still exists even though vaccine has been in plentiful supply for more than five years.

State Director of Health N. H. Dyer said recently that a scant 60 per cent of persons under 21 years of age have had the recommended course of shots while the figure is significantly less among older age groups in the State. Doctor Dyer said immunization of 80 per cent of the susceptible population is considered as the minimum necessary to "break the chain of infection" which can result in an epidemic.

The Health Director's warning was prompted by the state's first death from poliomyelitis for 1962. The victim was a four-year-old boy from Lincoln County who died on July 9, in Marmet Hospital.

Reporting in the department's weekly publication, "State of the State's Health," Doctor Dyer noted that the child had received no polio vaccine. He also observed that the year's only other case in West Virginia involved a 15-year-old girl from Putnam County who had not had vaccine.

Doctor Dyer urged parents to check with physicians regarding the immunization status of their children. In many cases, youngsters need additional shots to complete the initial series for basic immunization, he said, while others require booster shots.

Cautions Against Complacency

"And while they are about it, parents might do well to check on themselves," he asserted. The State health chief said that too much emphasis has been put on polio as a disease of children only. Last year the only reported death from the disease in West Virginia was that of a 49-year-old woman.

He cautioned against being "lulled into complacency" by declining numbers of cases of polio. "In 1954, when the Salk vaccine was first introduced in the State for field trials we recorded 392 cases," he said. "By 1957, the number had dropped to 59 cases. But the very next year our case load jumped to 216, and, in 1959, we listed another 196 cases."

Last year, West Virginia had only 34 cases of polio, he added, but because of the "cyclical nature of the disease and failure to reach required immunization levels" a close watch will be kept over progress of new cases.

Reduced Rates for Belt-Equipped Cars?

Doctor Dyer also proposed that all insurance companies doing business in the State cooperate in a pilot project to offer reduced rates to drivers whose cars are equipped with seat belts.

He said that a year-old campaign to get all cars equipped with the safety devices has been credited with saving nearly 100 lives in the nation and could save 350 to 400 additional lives in the next 12 months.

A national public education effort is being backed by the American Medical Association, the Public Health Service, the National Safety Council and most state health authorities.

Dr. William C. Morgan, Jr., Defending Golf Champion

The winner of the Medical Golf Tournament which will be held in connection with the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25, will receive a trophy offered by the Hospital and Physicians Supply Company of Charleston.

William C. Morgan, Jr., M. D.

Dr. William C. Morgan, Jr., of Charleston, won the first leg on the beautiful trophy when he shot a 77 to win the tournament in 1961.

His closest rival for low gross honors was Dr. R. R. Brown of Romney, who shot a 78. Other low scorers were Drs. Eugene J. Morhous of White Sulphur Springs, 79, Robert A. Crawford of Charleston, 80, Jack Leckie of Huntington, and Kenneth E. Owen of Washington, Ohio, 81, and Everett H. Starcher of Logan, 84.

Dr. Joseph A. Smith of Dunbar, chairman of the Golf Committee, said that physicians participating in the tournament will pay an entrance fee of $5, payable at the time they register for play in the tournament. There will be several prizes in addition to the championship trophy.

Physicians may engage in tournament play both mornings and afternoons during the three-day meeting. Participants are to inform the starter when they begin their official tournament round. All tournament play must be completed by four o'clock on Saturday afternoon, August 25.

Doctor Holroyd Reelected Secretary Of Aces and Deuces

Dr. Frank J. Holroyd of Princeton was reelected to a fourth consecutive term as secretary-treasurer of the Aces and Deuces organization at the annual breakfast meeting held at the Palmer House in Chicago on June 26. The meeting was attended by more than 150 persons.

Dr. H. Thomas McGuire of New Castle, Delaware, was elected president, succeeding Dr. Malcom E. Phelps of El Reno, Oklahoma.

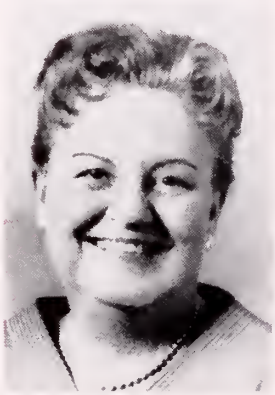
Other West Virginia physicians attending the meeting were Dr. and Mrs. D. E. Greeneltch of Wheeling, and Dr. Charles A. Hoffman of Huntington.

The Aces and Deuces is a social organization composed of AMA delegates and alternates from State Medical Associations and Societies which have one or two members in the House of Delegates.

An Aces and Deuces luncheon honoring AMA officers and members of the House of Delegates will be held during the clinical session in Los Angeles in November.

National Officers of Auxiliary To Attend Annual Meeting

More than 200 wives of physicians are expected to attend the 38th Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 23-25.



Mrs. William G. Thuss

Mrs. Roy A. Douglass

Mrs. Vernon L. Dyer of Petersburg, the President, will preside at the three-day meeting which will be held in conjunction with the 95th Annual Meeting of the State Medical Association.

Mrs. William G. Thuss of Birmingham, Alabama, who was installed as President of the Woman's Auxiliary to the American Medical Association in June, will be among the guest speakers and will deliver the keynote address at the opening session on Thursday morning, August 23.

Another honor guest will be Mrs. Roy A. Douglass of Huntingdon, Tennessee, President of the Woman's Auxiliary to the Southern Medical Association. She will present an address before the second session on Friday morning, August 24.

Pre-Convention Meetings

Mrs. Dyer will preside at a pre-convention meeting of the Executive Board which will be held at four o'clock on Wednesday afternoon, August 22, the day preceding the formal opening of the convention.

A cordial invitation has been extended to members of the Auxiliary to attend the first session of the Association's House of Delegates which will be held that same evening. Dr. D. E. Greeneltch of Wheeling, the President, will present his Presidential Address at that session.

General Heaton Guest Speaker

Physicians, wives and their families are invited to hear an address by Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army, at the Association's first general session in Governor's Hall at nine o'clock on Thursday morning. General Heaton, who is a native of Parkersburg, will speak on "The Role of Army Medical Research in National Defense."

General Business Sessions

The Auxiliary's general business sessions will be held on Thursday and Friday mornings, leaving the afternoons free for committee meetings and participation in the golf and bridge tournaments arranged in connection with the meeting.

Mrs. Dyer will preside at the opening session on Thursday morning and the invocation and pledge of loyalty will be given by Mrs. Clark K. Sleeth of Morgantown, a past president.

The agenda at the first session will include reports of convention committees and recommendations of the Executive Board. Reports of county auxiliary presidents also will be received, together with reports of the officers and the standing and special committees.

Address by Mrs. William G. Thuss

The guest speaker at the first session will be Mrs. William G. Thuss, the AMA Auxiliary President, who will deliver the keynote address.

Mrs. Thuss, who also appeared as a speaker at the 1961 meeting at The Greenbrier, has been active in Auxiliary work for more than thirty years. She is a native of Nashville, Tennessee, and was graduated from Vanderbilt University.

She is a past president of the Woman's Auxiliary to the Alabama State Medical Association and served as co-chairman of organization of the AMA Auxiliary, 1954-56. She served as director of the organization, 1956-58, and was southern regional vice president, 1958-60, prior to being named president elect in 1961.

Her husband is an industrial surgeon and they have three sons, two of whom are physicians. They have six grandchildren.

Mrs. Thuss is an active member of the American National Red Cross, American Cancer Society and the League for Nursing. She is a charter member of the Woman's Auxiliary to the International College of Surgeons and the Southeastern Surgical Congress.

Election of Officers on Friday

The annual past president's breakfast will be held at eight o'clock on Friday morning, with Mrs. Clark K. Sleeth of Morgantown, immediate past president, presiding. Mrs. Dyer will preside at the second general session which will be held at 9:30 A.M. on Friday. In addition to receiving reports of various committees, new officers will be elected for the coming year following a report of the nominating committee.

The first speaker at the Friday morning session will be Mr. John W. Pompelli of Chicago, AMA Field Representative. His subject will be "You Are One-Half of One Doctor's Team."

Mr. Pompelli has traveled extensively in West Virginia during the past year and is well known to physicians and their wives throughout the State.

Mrs. Thuss will install the newly elected officers. The presentation of the president's pin and gavel will be made by Mrs. Vernon L. Dyer to Mrs. Howard G. Weiler of Wheeling, the incoming president. The presentation of the past president's pin to Mrs. Dyer will be made by Mrs. Clark K. Sleeth.

Address by Mrs. Howard G. Weiler

Mrs. Howard G. Weiler, who will be installed as President, will deliver her inaugural address following the installation ceremonies.

The President of the Woman's Auxiliary to the Southern Medical Association, Mrs. Roy A. Douglass of Huntingdon, Tennessee, also will speak that morning. She was born in Nashville and was graduated from Vanderbilt University.

Mrs. Douglass is a past president of the West Tennessee Consolidated Auxiliary and the Woman's Auxiliary to the Tennessee State Medical Association. Prior to her election as president elect of the Woman's Auxiliary to the Southern Medical Association, she served as vice president and councillor from Tennessee.

Her husband received his M. D. degree from the Vanderbilt University School of Medicine. They have two children and eight grandchildren.

Mrs. Vernon L. Dyer
President

Luncheon and Fashion Show

A luncheon and fashion show will be held in the Crystal Dining Room for members and guests following adjournment of the second session on Friday morning. Fashions will be shown by Alanson's of The Greenbrier. Mrs. Harry F. Coffman of Keyser is in charge of arrangements.

Mrs. H. J. Maxwell of Petersburg is in charge of arrangements for the golf tournament which will be held that afternoon.

The Barter Players

The Woman's Auxiliary is in charge of the entertainment program for the convention. The feature entertainment will be a performance on Friday evening by the Barter Players of Abingdon, Virginia. The famous theatrical group will appear through the courtesy of the Potomac Valley Medical Society, and will present a musical comedy entitled "Fantasticks."

Post-Convention Conference

Mrs. Howard G. Weiler, the incoming president, will preside at a post-convention conference which will be held at 10 A.M. on Saturday, August 25. This meeting will be the final item of business on the formal program.

Second Session of House of Delegates

Dr. George M. Fister of Ogden, Utah, President of the American Medical Association, will be the principal speaker at the second session of the Association's House of Delegates at three o'clock on Saturday afternoon. Auxiliary members are cordially invited to attend both sessions of the House of Delegates.

The second session also will feature introductions of West Virginia's "General Practitioner of the Year," and the two recipients of the State Medical Association's 1962 four-year scholarships to the West Virginia University School of Medicine. The business session will include the election of officers for the coming year.

Presidential Dinner

The Presidential Dinner honoring Doctor Fister will be held in Chesapeake Hall on Saturday evening, August 25. The speaker will be the Rev. Robert P. Varley, Th. D., Rector of St. Peter's Episcopal Church in Salisbury, Maryland. He is a member of the Speaker's Bureau of the American Medical Association and has given talks before groups in 36 states during the past year.

A cocktail party and reception honoring the officers of the West Virginia State Medical Association will be held on the Chesapeake Hall Terrace from 6:30 to 7:30 that evening. All members of the Auxiliary, State Medical Association, exhibitors and guests are invited to attend.

Convention Committee

Mrs. L. T. Veach of Petersburg and Mrs. Thomas E. Bess of Keyser are co-chairmen of the convention. They were appointed by the President, Mrs. Vernon L. Dyer.

Booklet Available on Heart Clinics

The American Heart Association recently issued a newly revised 24-page booklet which defines the functions of a cardiovascular clinic in terms of service to patients, education not only of professional staff but of patients and their families, and research.

Copies of "Recommended Standards for Cardiovascular Clinics" are available to members of health departments, clinic staffs, hospital trustees and other professional personnel connected with community health problems. The booklet may be obtained from the West Virginia Heart Association, Box 5336, Capitol Station, Charleston.

Medicare Plan for Aged May Put U.S. on Road to State Atheism

Separation of church and state in America does not mean that religion and politics are unrelated. Both religion and politics are human activities. They are interwoven in our national life. Although it is a delicate subject, I see no reason why the relation of current legislation to our traditional beliefs should not be discussed occasionally.

Socialism is entirely anti-religious because it sets the material above the spiritual. Communism, the ultimate of socialism, is atheistic. Socialist-tending legislation, like the administration's medicare plan (H.R. 4222 and S 909), is a move toward godlessness and (with the United States founded in divine worship and trust) is un-American in the deepest sense.

Medicare attacks religion at the Fifth Commandment, which reads, "Honor thy father and mother." This legislation is uncompatible with the commandment. Under Medicare, most workers would have their pay checks nicked for an extra percentage, and these total takings from the national payroll would provide medical care for persons of 65 whether or not they needed the provision.

Thus, the state and not the children are caring for the aged. The legislation is not going to pass simply because old persons are for it. The best chance of cramming it through a resistant Congress is the administration's belief that young people see the legislation as a chance to shuck off the Biblical obligation to honor their aged parents.

It is typical of modern liberalism that intimate, personal relations are dismissed in favor of mass treatment. The AFL-CIO News calls parental dependence upon their children a "sorry reward" and a "catastrophe" of old age. This laborite journal declares that "in most cases (care of the old folks) is beyond the means of willing children" in this most prosperous of all nations.

Medicare goes anti-religious in other places. It assumes a stigma upon poverty which no religion on earth has ever countenanced. The Founder of Christianity said that the poor are "blessed." The one excuse that Marx had for so-called religion, the "opium" of the people, is that spiritual grace takes the stress off poverty and riches alike.

One omnipresent argument for federalized medical-care-for-everybody under Social Security is that it avoids the means-test or "pauper's oath" which would require an applicant to prove his need of public assistance. But everything in religion states that being poor is no disgrace. Only the liberal politicians seem to think so—or seem to be trying to teach Americans to think so.

While not a disgrace, poverty is a misfortune (often self-imposed, however) and something to be avoided by hard work. To take this incentive away from people, by supplying federal subsidies for almost every reason, is to imprison the people within the walls of federal aid and charity.

Medicare is anti-democratic in the worst way. The present law, known as the Kerr-Mills Act, gives money to the states on a matching basis requiring state authorities to decide who gets medical care because of age and need. But an apostle of liberalism, labor leader Walter Reuther, has no confidence that Congress and state legislatures will continue to do what they have promised. Reuther has said:

". . . the Kerr-Mills bill will require action each year on the part of the federal government to appropriate money for the coming year. It will require action on the part of the 50 state bodies, where they will have to appropriate money."

Reuther, the anti-democrat, doesn't trust our national and local legislators to do this.

Medicare attacks the so-called Protestant ethic, which is the philosophic-historical term for the Renaissance ideal of self-reliance and personal initiative. Along with the whole package of welfare-for-all legislation, Medicare does not encourage the citizen to put aside something from his earnings and to go into the market place to purchase suitable insurance. Medicare does these things for the citizen.—Holmes Alexander, in the Los Angeles Times.

American Diabetes Association Honors Charleston Woman

Mrs. Alan J. Arthur of Charleston received a citation as the "Outstanding Layman" for 1962 at the annual meeting of the American Diabetes Association which was held at the Conrad Hilton Hotel in Chicago, June 23-24.

Mrs. Alan J. Arthur

The presentation was made by Dr. Maurice Protas of Washington, D. C., chairman of the Assembly of State Governors and Affiliate Delegates.

Long active in work with diabetics, Mrs. Arthur was the first secretary of the Charleston Diabetes Association which is composed of lay members. She also is treasurer of Camp Kno-Koma, a summer camp for diabetic children.

She was nominated for the national honor by the West Virginia Diabetes Association.

Relocations

Dr. Edith Cserny of Huntington has accepted appointment as Senior Physician at the Veterans Administration Hospital in Perry Point, Maryland. Doctor Cserny had practiced in West Virginia for the past 10 years.

* * * *

Dr. Arnold C. Burke, who has been a member of the Pediatric Department at Beckley Memorial Hospital for more than six years, has moved to South Charleston and his office address there is 4502 MacCorkle Avenue, S. W.

New Booklet Published On Medical Careers

A new 32-page booklet, designed to help communities interest more students in careers in medicine, was published recently by Pfizer Laboratories and J. B. Roerig and Company, ethical drug divisions of Chas. Pfizer and Company, Inc.

The booklet is entitled "Your Career Opportunities in Medicine" and was prepared in cooperation with the Council on Medical Education and Hospitals of the American Medical Association.

Copies of the booklet are available free of charge to medical societies for distribution at health fairs and high school career day programs, and to educational guidance counsellors, science teachers, physicians and the public. Copies may be obtained by writing the Education Services Department, Chas. Pfizer and Company, Inc., 235 E. 42nd Street, New York 17, New York.

State Physicians Fare Well In AMA Tournaments

Two West Virginia physicians, Dr. Ralph Frazier of Fayetteville and Dr. George A. Curry of Morgantown, were among the winners in the bowling and golf tournaments held in connection with the Annual Meeting of the American Medical Association in Chicago in June.

Doctor Frazier rolled a 653 series to win the special senior handicap division for physicians in the first annual AMA bowling tournament.

Dr. George A. Curry of Morgantown and Dr. Wayne Spenader of Sublet, Illinois, tied for first place in handicap play of the American Medical Golf Association Tournament which was held at St. Andrew's Country Club in West Chicago.

Dr. W. H. Ferguson of Washington, D. C., posted the low net score of 71 among the 142 participants.

West Virginia Heart Association Accepts 273 New Members

The West Virginia Heart Association accepted 273 new members during a mid-year meeting of the Board of Directors which was held at the Daniel Boone Hotel in Charleston on June 24.

Dr. Morris H. O'Dell of Charleston, the president, said four delegates were elected to the annual meeting of the American Heart Association in Cleveland, October 25-30.

Dr. Upshur Higginbotham of Bluefield, West Virginia's representative on the American Heart Board, will be delegate-at-large. Those elected were Drs. O'Dell, Otis G. King of Bluefield and A. D. Kistin of Beckley, and Mrs. Frank Harris of Kenova.

Elected as alternate delegates were Jack L. Lewis of Bluefield, Richard Harz and Mrs. Laurence Meharg, both of Wheeling, and Dr. J. Keith Pickens of Clarksburg, the president elect.

Seventh Annual Postgraduate Institute At Martinsburg, Sept. 13-16

Plans have nearly been completed for the Seventh Annual Potomac-Shenandoah Valley Postgraduate Institute which will be held in Martinsburg, September 13-16.

The four-day meeting will be sponsored jointly by the Eastern Panhandle Medical Society and the West Virginia Chapter of the American Academy of General Practice.

Dr. Halvard Wanger of Shepherdstown, the general chairman, has announced that more than 20 prominent physicians and surgeons have accepted invitations to appear as guest speakers. He also announced that Dr. Morris Fishbein of Chicago and Dr. Chauncey Leake of Columbus will be the speakers at dinner meetings which will be held on Friday and Saturday evenings.

The following is a list of the physicians who will present papers during the meeting:

Drs. Robert J. Coffey and John M. Evans of Washington, D. C.; Warfield M. Firor, John D. Young, Jr., Frank D. Kaltreider, Leslie N. Gay, John C. Krantz, Louis A. M. Krause, Leonard Scherlis and Alexander J. Schaffer, all of Baltimore; Manuel E. Lichtenstein of Chicago; and William J. H. DeMaria of Durham, North Carolina.

Drs. Thomas H. McGavack of Martinsburg; Milton L. McCall of Pittsburgh; Henry S. Tucker, Jr., and Carolyn Moore McCue of Richmond; T. L. Montgomery, John H. Moyer, Bernard J. Alpers, John H. Hodges and Charles M. Thompson, all of Philadelphia; and Dr. Chauncey Leake of Columbus.

The meeting will be held during the Antietam Centennial Weekend and entertainment features will include the "Hill of Glory," outdoor spectacular in Hagerstown, Maryland, on Thursday evening; and the reenactment of the battle of Antietam in Sharpsburg, Maryland.

The complete program for the meeting will be published in the September issue of *The Journal*. Further information may be obtained by writing to Halvard Wanger, M. D., General Chairman, Box 175, Shepherdstown, West Virginia.

Motion Picture Schedule

Dr. Ralph H. Nestmann of Charleston, chairman of the motion picture program for the Annual Meeting at The Greenbrier, has announced that two films will be shown each morning prior to the general scientific sessions.

The films on Thursday morning will be "External Cardiac Massage" and Thromboendarterectomy of the Left Common Carotid Bifurcation." On Friday morning the films will be "Lesions of the Brain—Head Injury," and "Carcinoid Syndrome—Primary Carcinoid of the Stomach."

The films on Saturday morning will be "Diagnostic Proctoscopy" and "Grand Rounds #10—Lesions of the Brain—Stroke."

PRESIDENTIAL DINNER

95th Annual Meeting

West Virginia State Medical Association

SPEAKER

The

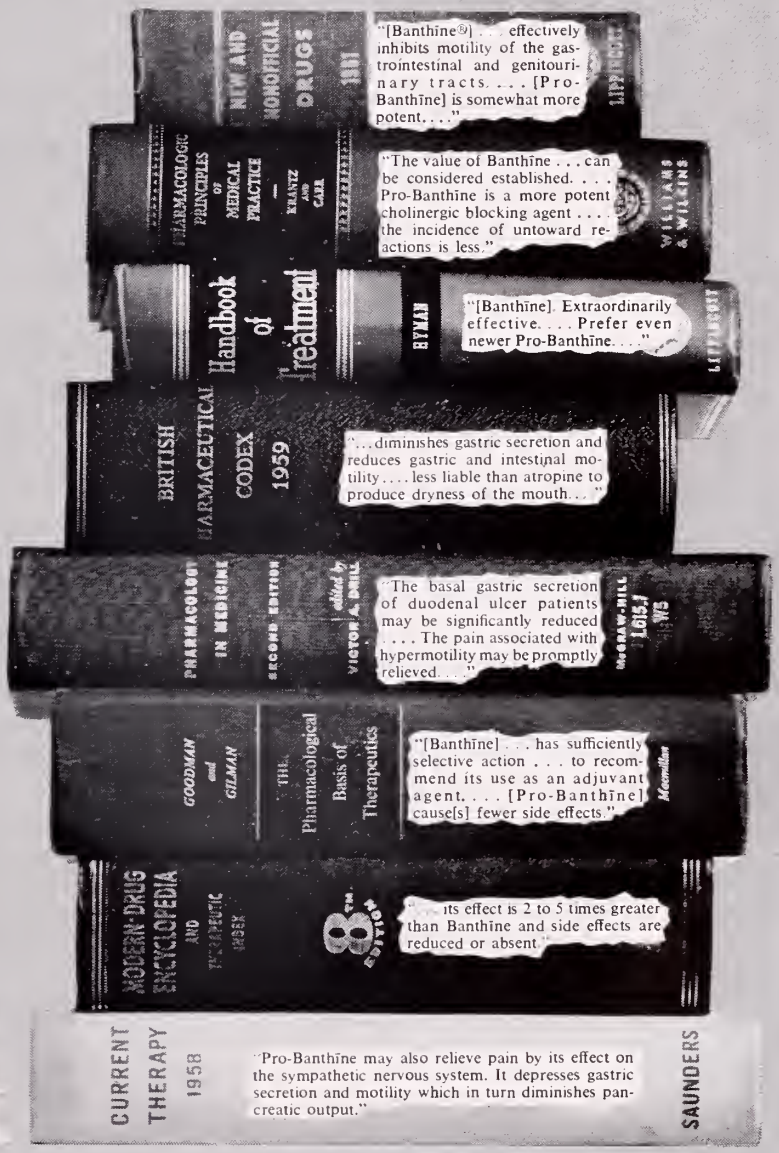
Rev. Robert P. Varley, Th. D.

Salisbury, Maryland

The Greenbrier — Chesapeake Hall

SATURDAY EVENING, AUGUST 25—7:30 O'CLOCK

Tickets Will be Placed On Sale in the Registration Area at The Greenbrier
Beginning Wednesday Afternoon, August 22.



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CONVENTION PROGRAM

95th Annual Meeting

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS

August 23-25, 1962

WEDNESDAY AFTERNOON

August 22

(Eastern Standard Time)

2:30-4:30—Registration, Main Floor Lobby.

2:00—Committee on Rehabilitation. J. C. Pickett, M. D., *presiding.* (Buchanan Room).

2:30—Committee on Medical Education, Hospitals and Scholarships. Russel Kessel, M. D., *presiding.* (Van Buren Room).

3:00—Insurance Committee. Charles A. Hoffman, M. D., *presiding.* (Jackson Room).

4:00—Pre-Convention Meeting of the Council. John W. Hash, M. D., *presiding.* (Lee Room, Virginia Wing).

WEDNESDAY EVENING

8:30-9:30—Registration.

9:00—First Session of the House of Delegates. D. E. Greeneltch, M. D., *presiding.* (Chesapeake Hall).

Presidential Address—D. E. Greeneltch, M. D., President, West Virginia State Medical Association.

Business Meeting.

THURSDAY MORNING

August 23

8:00—Motion Pictures. Ralph H. Nestmann, M. D., in charge. (Governor's Hall). "Thromboendarterectomy of the Left Common Carotid Bifurcation," and "External Cardiac Massage."

8:30-5:00—Registration, Main Floor Lobby.

Opening Exercises

(Governor's Hall)

9:00—Call to Order—Halvard Wanger, M. D., Chairman, Program Committee.

Invocation—Tracy N. Spencer, Jr., M. D.

Address of Welcome—D. E. Greeneltch, M. D., President, West Virginia State Medical Association.

Address by Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army. Subject: "The Role of Army Medical Research in National Defense."

First General Session

(Governor's Hall)

Moderator: Charles D. Hershey, M. D.

9:45—I. S. Ravdin, M. D., Professor of Surgery and Vice President of Medical Affairs, University of Pennsylvania, Philadelphia. Subject: "Cancer Chemotherapy."

10:30—Recess for Visiting Exhibits.

11:00—A. Edward Maumenee, M. D., Professor of Ophthalmology, Johns Hopkins University School of Medicine, Baltimore. Subject: "Ocular Manifestations of General Medical Disease."

11:45—Otto C. Phillips, M. D., Professor of Anesthesiology, University of Pittsburgh School of Medicine, Pittsburgh. Subject: "Factors in Obstetrical Mortality: The Role of Anesthesia."

12:30—Recess for Lunch and Visiting Exhibits.

THURSDAY AFTERNOON

August 23

2:00—Resolutions Committee. Albert C. Esposito, M. D., *presiding.* (Tyler Room).

2:00—Open Meeting, West Virginia State Society of Allergy. (Governor's Hall).

Address of Welcome—M. D. Reiter, M. D., President of the Society.

Scientific Program with Merle S. Scherr, M. D., as *Moderator.*

Guest Speakers: William A. Hopkins, M. D., Atlanta, Georgia. Subject: "Chronic Lung Disease: Group and Clinic Therapy."

Gustav J. Beck, M. D., New York City. Subject: "Physiologic Considerations in the Management of Bronchial Asthma and Pulmonary Emphysema."

Irving W. Schiller, M. D., Boston. Subject: "A Brief Review of Drug Therapy in Bronchial Asthma."

Panel Discussion and Question and Answer Period.

2:00—Section on Surgery. A. Kyle Bush, M. D., *presiding.* (Mountaineer Room).

Guest Speaker: I. S. Ravdin, M. D., Philadelphia. Subject: "Cancer of the Large Bowel."

2:00—Section on Industrial Medicine and Public Health. George F. Fordham, M. D., *presiding.* (Blue Ridge Room).

THURSDAY EVENING

6:30—Cocktail Party, West Virginia Chapter, Medical College of Virginia Alumni Association. Carl B. Hall, M. D., in charge. (West Virginia Room).

10:00—Dancing in the Ballroom.

FRIDAY MORNING

August 24

8:15—Motion Pictures. Ralph H. Nestmann, M. D., in charge. (Governor's Hall.) "Carcinoid Syndrome—Primary Carcinoid of the Stomach," and "Lesions of the Brain—Head Injury."

8:30-5:00—Registration, Main Floor Lobby.

Second General Session

(Governor's Hall)

Moderator: Thomas H. McGavack, M. D.

9:30—Stewart G. Wolf, M. D., Professor and Head, Department of Medicine, University of Oklahoma School of Medicine, Oklahoma City, Oklahoma. Subject: "The Relation of Life Stress to Serum Lipids in Patients with Coronary Artery Disease."

10:15—William S. Middleton, M. D., Chief Medical Director, Veterans Administration, Washington, D. C., and Dean Emeritus and Professor of Medicine Emeritus, University of Wisconsin Medical School. Subject: "Abdominal Angina."

11:00—Recess for Visiting Exhibits.

11:30—Irving S. Wright, M. D., Professor of Clinical Medicine, Cornell University Medical College, New York City. Subject: "The Modern Treatment of Cerebrovascular Diseases."

12:15—Recess for Lunch and Visiting Exhibits.

FRIDAY AFTERNOON

August 24

2:00—Section on Internal Medicine. Richard V. Lynch, Jr., M. D., *presiding.* (Governor's Hall).

Guest Speakers: Irving S. Wright, M. D., New York City. Subject: "Anticoagulant Therapy: A Matter For Discrimination."

Stewart G. Wolf, M. D., Oklahoma City. Subject: "A Critical Appraisal of Therapy with Notes on the Action of Placebos."

William S. Middleton, M. D., Washington, D. C. Subject: "Collagen Diseases Revisited."

Business Meeting.

2:00—Section on Urology. Thomas B. Baer, M. D., *presiding.* (Jackson Room).

Guest Speaker: George M. Fister, M. D., Ogden, Utah. Subject: "Colloids of the Human Urine."

2:00—West Virginia Academy of Ophthalmology and Otolaryngology. Albert C. Esposito, M. D., *presiding.* (Mountaineer Room).

Guest Speaker: A. Edward Maumenee, M. D., Baltimore. Subject: "The Management of Glaucoma and Glaucoma Surgery."

Business Meeting.

2:00—Section on Orthopedic Surgery. Earl A. McCowen, M. D., *presiding.* (Allegheny Room).

Guest Speaker: Hugh L. Sulfridge, Jr., M. D., Saginaw, Michigan. Subject: "Manipulative Treatment of Spinal Disorders."

2:00—West Virginia Obstetrical and Gynecological Society. John T. Chambers, M. D., *presiding.* (Fillmore Room).

Guest Speaker: H. L. Riva, M. D., Jersey City, New Jersey. Subject: "Management of Endometriosis."

2:00—West Virginia Radiological Society. Hubert A. Shaffer, M. D., *presiding.* (West Virginia Room).

Guest Speaker: John W. Hope, M. D., Philadelphia. Subject: "Intestinal Obstruction in the Newborn."

3:30—West Virginia Pediatric Society. Grover C. Hedrick, M. D., *presiding.* (Tyler Room).

Guest Speaker: James G. Hughes, M. D., Memphis, Tennessee. Subject: "Behavioral Problems in Children."

4:00—Section on Neurology, Neurosurgery and Psychiatry. Thomas J. Holbrook, M. D., *presiding.* (Blue Ridge Room).

Guest Speaker: Stewart G. Wolf, M. D., Oklahoma City. Subject: "Neural Mechanisms in Systemic Disease."

5:00—Committee on Nominations. J. C. Huffman, M. D., *presiding.* (Lee Room).

FRIDAY EVENING

9:00—Auxiliary Entertainment Program.

The Barter Players of Abingdon, Virginia.—Presented through the courtesy of the Potomac Valley Medical Society. (Chesapeake Hall). The Players will present a musical comedy entitled "Fantasticks."

SATURDAY MORNING

August 25

8:00—Motion Pictures. Ralph H. Nestmann, M. D., in charge. (Governor's Hall). "Diagnostic Proctoscopy," and "Grand Rounds #10—Lesions of the Brain-Stroke."

8:30-3:30—Registration, Main Floor Lobby.

Third General Session

(Governor's Hall)

Moderator: George P. Heffner, M. D.

9:30—James G. Hughes, M. D., Professor and Head of the Division of Pediatrics, University of Tennessee College of Medicine, Memphis. Subject: "Epilepsy in Children."

10:15—John W. Hope, M. D., Director, Department of Radiology, The Children's Hospital of Philadelphia. Subject: "Roentgen Facts and Fallacies Regarding the Chest of Infants and Children."

11:00—Recess for Visiting Exhibits.

11:30—H. L. Riva, M. D., Professor and Chairman, Department of Obstetrics and Gynecology, Seton Hall College of Medicine, Jersey City. Subject: "Preventive Medical Measures in Obstetrics and Gynecology."

12:15—Recess for Lunch and Visiting Exhibits.

SATURDAY AFTERNOON

August 25

1:00—West Virginia Society of Anesthesiologists. Harry S. Weeks, Jr., M. D., *presiding.* (Fillmore Room).

Guest Speaker: Otto C. Phillips, M. D., Pittsburgh. Subject: "Complications of Spinal Anesthesia—Prophylaxis and Management."

1:30—West Virginia Association of Pathologists. David B. Thornburgh, M. D., *presiding.* (Jackson Room).

Business Meeting.

3:00—Second and Final Session of the House of Delegates. D. E. Greeneltch, M. D., *presiding.* (Theatre)

Address: George M. Fister, M. D., President, American Medical Association.

Introduction of West Virginia's "General Practitioner of the Year."

Introduction of President of Woman's Auxiliary and Honor Guests.

Introduction of Presidents of Neighboring State Medical Associations.

Introduction of Recipients of 1962 Medical Scholarship Awards.

Business Meeting.

Election of Officers.

Installation of L. J. Pace, M. D., of Princeton, as President of the West Virginia State Medical Association.

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association. (Chesapeake Hall Terrace).

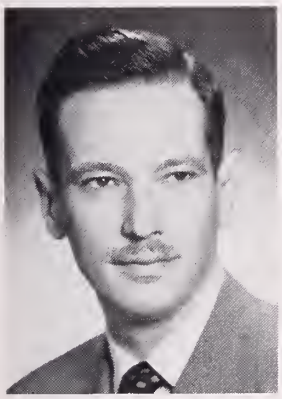
7:30—Presidential Dinner honoring George M. Fister, M. D., President of the American Medical Association. (Chesapeake Hall).

Speaker: The Rev. Robert P. Varley, Th.D., Rector, St. Peter's Episcopal Church, Salisbury, Maryland. Subject: "Individual Integrity or Social Suicide."

CONVENTION SPEAKERS

(Biographical Sketches)

Gustav J. Beck, M. D., of New York City, Instructor in Medicine, Columbia University College of Physicians and Surgeons, is a native of Vienna, Austria. He was graduated from Columbia University and received his M. D. degree in 1944 from the New York University College of Medicine.



Gustav J. Beck, M. D.

He served his internship at Bellevue Hospital, 1944-45, and served a residency at Goldwater Memorial Hospital, 1945-48.

Doctor Beck is a Fellow of the American College of Chest Physicians and is a member of the American Medical Association, Aerospace Association, American Thoracic Society and the New York Academy of Science. He is Secretary of the Air Pollution Committee of the ACCP.

He was awarded a certificate of merit by the American Medical Association in 1955.

George M. Fister, M. D., of Ogden, Utah, President of the American Medical Association, was born in Logan, Utah. He was graduated from Utah State University and received his M. D. degree in 1918 from Rush Medical College in Chicago. Following an internship at Henry Ford Hospital in Detroit, he engaged in general practice for four years in Brigham City, Utah.

George M. Fister, M. D.

He then returned East for special studies in the field of urology and did postgraduate work in London and Vienna. He located in Ogden in 1928 where he has been engaged continuously in the practice of his specialty.

A past president of the Western Section of the American Urological Association, Doctor Fister serves as Clinical Lecturer in Surgery at the University of Utah College of Medicine. He has written a number of scientific papers on various types of genitourinary tract diseases.

Doctor Fister, who was installed as President of the American Medical Association during the Annual Meeting in Chicago in June, is a past President of the Utah State Medical Association. He served for several years as Utah's delegate to the AMA House of Delegates and was Chairman of the AMA Council on Legislative Activities. He also served as a member of the AMA Board of Trustees prior to being named president elect in 1961.

Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army, is a native of Parkersburg. He attended Denison University in Granville, Ohio, and received his M. D. degree in 1926 from the University of Louisville School of Medicine.

Lt. Gen. Leonard D. Heaton

After entering the military service in 1926 as a First Lieutenant, Medical Corps Reserve, he interned at Letterman General Hospital in San Francisco, California, 1926-27, and was commissioned as a First Lieutenant, MC, Regular Army, on August 3, 1927.

General Heaton graduated from the Army Medical School and the Medical Field Service School in 1929. Following his internship he was assigned to surgery at Letterman General Hospital in San Francisco. He later served on the Surgical Service at Walter Reed General Hospital in Washington, D. C.; Beaumont General Hospital at El Paso, Texas; Tripler General Hospital, Hawaii; and the Station Hospital at Fort Sam Houston in Texas.

At the time of the Japanese attack on Pearl Harbor, he was serving as Chief of Surgery at the North Sector General Hospital, Schofield Barracks.

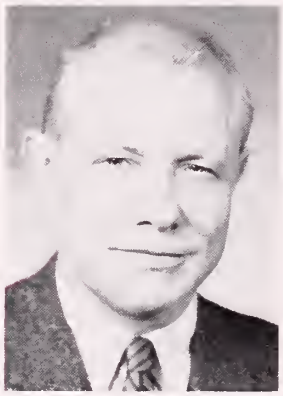
He also has served as Executive Officer of Woodrow Wilson General Hospital in Staunton, Virginia; and Commanding Officer of the 160th General Hospital and Commanding Officer of the 802nd Hospital Center, Blanford, England.

He was Chief of the Surgical Service and Commanding General at Letterman General Hospital in San Francisco; and Commanding General, Walter Reed Army Medical Center in Washington.

He was promoted to Brigadier General in 1948 and Major General in 1950. After taking the oath of office as Surgeon General of the Army in 1959, he was appointed to the rank of Lieutenant General.

General Heaton is a diplomate of the American Board of Surgery and is a member of the American Medical Association, American College of Surgeons, American College of Physicians, and the American Surgical Association.

John W. Hope, M. D., of Philadelphia, Director of the Department of Radiology at the Children's Hospital of Philadelphia, and Professor of Clinical Radiology, University of Pennsylvania School of Medicine and Graduate School of Medicine, was born in Chicago.



John W. Hope, M. D.

He was graduated from Stanford University and received his M. D. degree from the Stanford University School of Medicine in 1940. He served residencies at Stanford Lane Hospital, 1940-42, and at the Graduate School of Medicine and Hospital of the University of Pennsylvania, 1947-50. He served with the Medical Corps of the United States Navy, 1942-47, and was released with the rank of Lieutenant Commander. He was certified by the American Board of Radiology in 1950.

Doctor Hope is a Fellow of the American College of Radiology and is a member of the Radiological Society of North America, the American Roentgen Ray Society, and serves as a consultant in radiology to several hospitals in the Philadelphia area.

William A. Hopkins, M. D., of Atlanta, Georgia, Instructor in Thoracic Surgery, Emory University School of Medicine, was born in Raleigh, North Carolina. He received his M. D. degree in 1941 from Emory University School of Medicine and served his internship and had residency training at Grady Memorial Hospital in Atlanta, 1941-44.

William A. Hopkins, M. D.

He also served residencies in thoracic surgery at Emory University Hospital and Lawson VA Hospital in Chamblee, Georgia, 1946-48. He served with the Medical Corps of the United States Navy, 1944-46.

He is a Diplomate of the American Boards of Surgery and Thoracic Surgery and a Fellow of the American College of Surgeons and the American College of Chest Physicians. He is a member of the Fulton County Medical Association, Georgia Medical Association and American Medical Association.

Doctor Hopkins is President of the Georgia Trudeau Society, and is also attending thoracic surgeon at Grady Memorial Hospital in Atlanta.

James G. Hughes, M. D., of Memphis, Tennessee, Professor and Head of the Division of Pediatrics, University of Tennessee College of Medicine, was born in Memphis. He was graduated from Southwestern University and received his M. D. degree from the University of Tennessee College of Medicine in 1935.

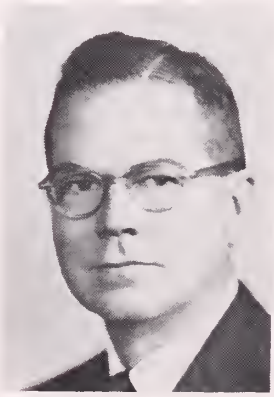
James G. Hughes, M. D.

He interned at John Gaston Hospital in Memphis, 1935-37, and served residencies in pediatrics at that hospital and at the Children's Memorial Hospital in Chicago, 1937-39.

He served with the Medical Corps of the United States Army during World War II and was released with the rank of Colonel. He served as Assistant and Associate Professor of Pediatrics and was named Professor in 1952 at the University of Tennessee College of Medicine. He was named Head of the Division in 1960.

Doctor Hughes is a Diplomate of the American Board of Pediatrics and has served as Chairman of the Committee on Medical Education of the American Academy of Pediatrics.

A. Edward Maumenee, M. D., of Baltimore, Professor of Ophthalmology, Johns Hopkins University School of Medicine, was born in Mobile, Alabama. He was graduated from the University of Alabama and received his M. D. degree in 1938 from Cornell University School of Medicine.



A. Edward Maumenee, M. D.

Doctor Maumenee served as an intern and assistant resident in ophthalmology at Johns Hopkins Hospital, 1938-42, and was resident ophthalmologist, 1942-43. He served as a member of the faculty at Johns Hopkins from 1939 until 1948, at which time he was appointed Professor of Surgery in Ophthalmology at the Stanford University School of Medicine. He returned to Johns Hopkins as Professor of Ophthalmology in 1955.

Doctor Maumenee served as a Lieutenant in the Medical Corps of the United States Navy, 1944-46.

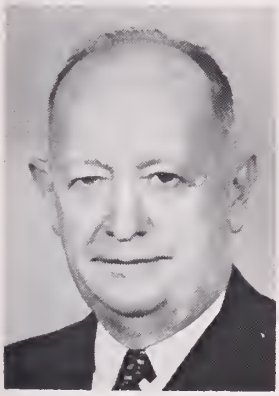
He is Ophthalmologist-in-Chief at Johns Hopkins Hospital and also serves as civilian consultant to Walter Reed Army Hospital, United States Naval Hospital in Bethesda, Maryland, and the Clinical Center of the National Institutes of Health.

Doctor Maumenee was certified by the American Board of Ophthalmology in 1943 and he is a member of the American Academy of Ophthalmology and Otolaryngology, and the American Ophthalmological Society.

He is a member of the American Board of Ophthalmology and Otolaryngology and has served as a member of the Advisory Council of the Council for Research in Glaucoma and Allied Diseases since 1956.

Doctor Maumenee served as a consultant to the United States Public Health Service, National Institute of Neurological Diseases and Blindness, National Institutes of Health, Graduate Training Committee, 1953-55. He has been a director of the National Society for the Prevention of Blindness since 1955.

William S. Middleton, M. D., of Washington, D. C., Chief Medical Director of the Veterans Administration and Dean Emeritus and Professor of Medicine Emeritus at the University of Wisconsin Medical School, was born in Norristown, Pennsylvania.


William S. Middleton, M. D.

He received his M. D. degree in 1911 from the University of Pennsylvania School of Medicine, and served his internship at the Philadelphia General Hospital.

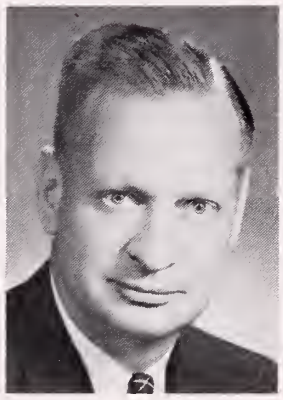
He served as Instructor, Professor of Medicine and Dean of the University of Wisconsin Medical School during the period from 1912 to 1955.

During World War I, Doctor Middleton served with British and American Expeditionary Forces in France, 1917-19. In World War II, he was Chief Consultant in Medicine to the European Theatre of Operation, 1942-45. He served as Special Advisor to the Surgeon General of the Army during the Korean conflict.

He has been awarded honorary degrees by the University of Pennsylvania, 1946; University of Cambridge, 1950; Temple University, 1956; Franklin and Marshall, 1957; and Marquette University, 1958.

Doctor Middleton appeared as a speaker at the 90th Annual Meeting at The Greenbrier in 1957. He also was one of the principal speakers at Dedicatory Ceremonies for the Basic Sciences Building at the West Virginia University Medical Center in 1957.

Otto C. Phillips, M. D., of Pittsburgh, Professor of Anesthesiology, University of Pittsburgh School of Medicine, was born in Baltimore. He was graduated from Johns Hopkins University and received his M. D. degree from the University of Maryland School of Medicine in 1942. He served his internship at St. Joseph's Hospital in Baltimore, 1942-43, and was graduated in 1945 from the School of Aviation Medicine at Randolph Field in Texas.


Otto C. Phillips, M. D.

Doctor Phillips served a residency in surgery at the Maryland General Hospital in Baltimore, 1946-47, and served as a Fellow in Anesthesia at the Lahey Clinic in Boston, 1947-49. He served as assistant professor of clinical anesthesia at the University of Maryland School of Medicine, 1955-61, and also served during the same period as chief of anesthesia at the Hospital for the Women of Maryland in Baltimore. In addition to his present duties at the University of Pittsburgh, he is also serving as chief of anesthesia at the Elizabeth Steel Magee Hospital in that city.

He is a Diplomate of the American Board of Anesthesiology and has served since 1954 as Chairman of the Baltimore Anesthesia Study Committee. He served as President of the Maryland Society of Anesthesiologists, 1956-57, and as chairman of the Maternal Welfare Committee of the American Society of Anesthesiologists, 1960-61.

I. S. Ravdin, M. D., of Philadelphia, Professor of Surgery and Vice President for Medical Affairs at the University of Pennsylvania, is a native of Evansville, Indiana. He received his M. D. degree in 1918 from the University of Pennsylvania School of Medicine and served an internship and residency at the University of Pennsylvania Hospital.

I. S. Ravdin, M. D.

Doctor Ravdin is immediate past president of the American College of Surgeons and he served for six years as a member and chairman of the Board of Regents of that organization. He also is a past president of the American Surgical Association and the International Society of Blood Transfusion.

He is now serving as vice president of the American Cancer Society and will be installed as president elect in October.

Doctor Ravdin is Chairman of the Clinical Studies Panel, Cancer Chemotherapy National Service Center, National Institutes of Health, and a member of the National Advisory Health Council. He also serves as Senior Civilian Consultant to the Surgeon General of the United States Army.

H. L. Riva, M. D., of Jersey City, New Jersey, Professor and Chairman of the Department of Obstetrics and Gynecology, Seton Hall College of Medicine, is a native of Charleroi, Pennsylvania. He received his M. D. degree in 1939 from the University of Pittsburgh School of Medicine, and served an internship at St. Francis Hospital in Pittsburgh, 1939-40.

H. L. Riva, M. D.

He was Chief of Surgical Service at Fort Holabird Hospital in Baltimore, Maryland, 1940-43, and served as Commanding Officer and Chief of General Surgery with the 28th Portable Surgical Hospital, 1943-46.

He served a residency in obstetrics and gynecology at Walter Reed General Hospital, 1946-49, and was Chief of Obstetrics and Gynecology at Walter Reed from 1949 to 1961.

Doctor Riva served as Clinical Associate Professor of Obstetrics and Gynecology at Georgetown University School of Medicine, 1957-61; Consultant in Obstetrics and Gynecology to the Surgeon General, United States Army, 1952-61; and Consultant in Obstetrics and Gynecology to the White House, 1953-61.

He was certified by the American Board of Obstetrics and Gynecology in 1949 and he is a member of the American Medical Association, American College of Surgeons, and the American College of Obstetricians and Gynecologists.

He serves as Military Consultant in Obstetrics and Gynecology to Walter Reed Army Institute of Research and the Armed Forces Institute of Pathology for Medical Illustration, Motion Pictures and Television Programming.

He also is consultant in emergency birth and mass casualty for the United States Army Medical Service Visual Manual, developed by Medical Illustration Service, A.F.I.P.

He was named an honorary member of the West Virginia Obstetrical and Gynecological Society in 1959.

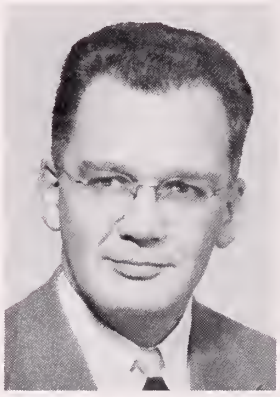
Irving W. Schiller, M. D., of Boston, Associate Clinical Professor of Medicine, Tufts University School of Medicine. He received his M. D. degree in 1930 from Tufts University School of Medicine and served his internship and had residency training at the Boston City Hospital, 1931-34.

Irving W. Schiller, M. D.

He served as an instructor in medicine at Tufts University School of Medicine, 1936-41, and also served as an instructor in medicine at the Boston University School of Medicine, 1945-50. He served from 1950 to 1958 as assistant professor of medicine at Boston University.

Doctor Schiller is co-physician-in-chief, Allergy Clinic, Boston Dispensary—New England Medical Center. He is a Fellow of the American College of Physicians, American College of Chest Physicians, American College of Allergists and a member of the New York Academy of Science.

Hugh L. Sulfridge, Jr., M. D., of Saginaw, Michigan, who has been engaged in the practice of his specialty of orthopedic surgery in that city since 1949, was graduated from the University of Virginia in 1937. He received his M. D. degree from the University of Virginia School of Medicine in 1941, and served an internship at Harper Hospital in Detroit, Michigan, 1941-42.



Hugh L. Sulfridge, M. D.

During World War II, he served as a medical officer in the Medical Corps of the United States Navy and Marines.

Following duty with the Armed Forces, he served residencies in orthopedic surgery at Harper Hospital and the Children's Hospital of Michigan in Detroit, 1945-49. Doctor Sulfridge was certified by the American Board of Orthodepic Surgery in 1953, and he is a Diplomate of the American Academy of Orthopedic Surgeons.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 95th Annual Meeting of The West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25, 1962.

The Rev. Robert P. Varley, Th. D., Rector of St. Peter's Episcopal Church in Salisbury, Maryland, was graduated from Carroll College, Waukesha, Wisconsin, and received his B. D. degree from Nashotah Seminary, also in Wisconsin.

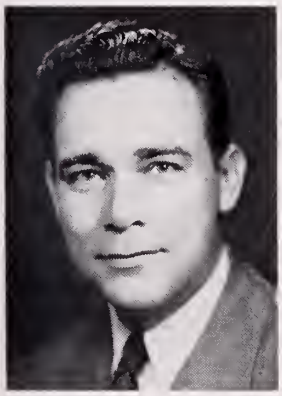
Rev. Robert P. Varley

Doctor Varley had postgraduate work at the Philadelphia Divinity School, from which he received both his Master's and Doctor's degrees. He became Rector of St. Peter's Church in 1956, following a five-year rectorship in Beverly, New Jersey.

Within the Episcopal Church, Doctor Varley is Secretary of the Diocese of Easton, and a member of the Standing Committee of that Diocese. On the national level, Doctor Varley is a member of the Episcopal Church's Joint Commission on the Church in Human Affairs, and is Secretary of this group.

He is a member of the American Academy of Religion and Mental Health and was the recipient of the Distinguished Service Award by the Salisbury Junior Chamber of Commerce in 1956. He also serves as a member of the Speaker's Bureau of the American Medical Association.

Stewart G. Wolf, M. D., of Oklahoma City, Professor and Head of the Department of Medicine, University of Oklahoma School of Medicine, is a native of Baltimore. He was graduated from Yale University and received his M. D. degree from Johns Hopkins University School of Medicine.



Stewart G. Wolf, M. D.

He served a residency in medicine at New York Hospital and also served as a Research Fellow in Medicine at Bellevue Hospital and participated in research on head injury and motion sickness with the Harvard Neurological Unit at Boston City Hospital.

He served with the Ninth General Hospital, the affiliated unit of Cornell in Australia, New Guinea and the Philippines during World War II.

From 1946 to 1952, Doctor Wolf served as Assistant and then as Associate Professor of Medicine at Cornell University Medical College. He also was Clinical Associate Visiting Neuropsychiatrist at Bellevue Hospital.

He was named to his present position in 1952. He also serves as Consultant Professor of Neurology and Psychiatry, Head, Psychosomatic and Neuromuscular Section, Oklahoma Medical Research Foundation; and Consultant in Internal Medicine to the VA Hospital in Oklahoma City.

Doctor Wolf is a past president of the American Federation for Clinical Research and served as President of the American Psychosomatic Society in 1961. He received the award of the American Gastroenterological Association for distinguished research in gastroenterology in 1943 and the Hofheimer Prize for research in 1952.

Irving S. Wright, M. D., of New York City, Professor of Clinical Medicine, Cornell University Medical College, is a native of New York City. He was graduated from Cornell University and received his M. D. degree in 1926 from Cornell University Medical College.

Irving S. Wright, M. D.

He served as Professor of Clinical Medicine and Director of the Department of Medicine at New York Postgraduate Hospital and the Columbia University College of Physicians and Surgeons, 1938-46.

During World War II, Doctor Wright served as Consultant in Medicine to the Surgeon General of the United States Army and Air Surgeon with the rank of Colonel. He also was Chief Coordinator of a Survey of the Health of Repatriated American Prisoners of War of the Japanese. He served from 1946 to 1948 as a member of the Civilian Advisory Committee to the Secretary of the Navy.

Doctor Wright is a past president of the American Heart Association and was the recipient of the Albert Lasker Award in 1960. He served as chairman of the Section on Experimental Medicine and Therapeutics of the American Medical Association, 1938-39.

He is certified by the American Board of Internal Medicine and is a Regent of the American College of Physicians. He has been a member of the editorial board of the American Heart Association since 1950, and also served as a member of the board of *Annals of Internal Medicine*, 1957-59.

95TH ANNUAL MEETING

of the

West Virginia State Medical Association

THE NEW WEST VIRGINIA WING

The Greenbrier

AUGUST 23-25, 1962

Plan to Attend — Make Your Reservation . . . Now !

DELEGATES AND ALTERNATES

B-R-T (3)—Delegates, A. Kyle Bush, Philippi; and Charles L. Leonard and Raymond W. Sass, Elkins. Alternates, Bill Robert Blackburn, Elkins; Ernest G. Guy, Philippi; and S. M. Lilienfeld, Parsons.

BOONE (2)—Delegates, O. D. MacCallum and Harold H. Howell, Madison. Alternates, W. F. Harless, Madison; and W. V. Wilkerson, Whitesville.

BROOKE (2)—Delegates, William T. Booher, Jr., Wellsburg; and James E. Wise, Follansbee. Alternates, James P. McMullen, Wellsburg; and Ralph McGraw, Follansbee.

CABELL (8)—Delegates, C. Stafford Clay, Huntington; W. D. Bourn, Barboursville; and D. Sheffer Clark, W. L. Neal, Richard J. Stevens, Albert C. Esposito, Thomas G. Folsom and I. Ewen Taylor, Huntington. Alternates, Roy A. Edwards, Jr., Sarah L. C. Stevens, James A. Heckman, Milford Hobbs, H. E. Beard, John M. Bobbitt, Jack Leckie and James P. Carey, Huntington.

CENTRAL WEST VIRGINIA (3)—Delegates, J. E. Echols, Richwood; Charles T. Lively, Weston; and Ira F. Hartman, Buckhannon. Alternates, C. R. Davisson and Elden H. Pertz, Weston; and Charles F. Morrison, Sutton.

EASTERN PANHANDLE (3)—Delegates, Halvard Wanger, Shepherdstown; and E. Andrew Zepp and C. V. Townsend, Martinsburg. Alternates, F. A. Hamilton, Jr., and N. B. Groves, Martinsburg; and S. Elizabeth McFetridge, Shepherdstown.

FAYETTE (3)—Delegates, W. P. Bittinger, Summerlee; Joe N. Jarrett, Oak Hill; and T. Kerr Laird, Montgomery. Alternates, Marvin Kirsh, Montgomery; Ivan H. Bush, Jr., Oak Hill; and Chuan H. Lee, Montgomery.

GREENBRIER VALLEY (3)—Delegates, Ilona Scott and Robert G. Shirey, Lewisburg; and Harvey A. Martin, White Sulphur Springs. Alternates, George H. Guy, Union; and Claude L. Houck, Lewisburg.

HANCOCK (3)—Delegates, E. M. Clubb, Jr., and R. E. Flood, Weirton; and David S. Pugh, Chester. Alternates, Myer Bogarad, Weirton; and J. M. Brand, Chester.

HARRISON (4)—Delegates, James A. Thompson, R. T. Humphries, E. Burl Randolph and Richard K. Hanifan, Clarksburg. Alternates, Andrew J. Weaver and J. D. H. Wilson, Clarksburg; David M. Robinson, Bridgeport; and Charles S. Harrison, Clarksburg.

KANAWHA (13)—Delegates, George R. Callender, Jr., Carrel M. Caudill, Arthur C. Chandler, Donald R. Gilbert and James H. Getzen, Charleston; Ralph J. Holloway, South Charleston; Milton J. Lilly, Charleston; James S. Kessel, Ripley; and Richard N. O'Dell, William B. Rossman, Robert C. Bock, Ralph H. Nestmann and Alfred J. Magee, Charleston. Alternates, Spencer L. Bivens and Marshall J. Carper, Charleston; William D. Crigger, South Charleston; R. O. Dawson, George V. Hamrick, James W. Lane, Arthur K. Lampton, George H. Pierson, Jr., Thomas G. Potterfield, Grover B. Swoyer and W. A. Thornhill, Jr., Charleston; Richard C. Wallace, St. Albans; and John G. Zekan, Charleston.

LOGAN (3)—Delegates, John R. Wilkinson, Jr., Luke Combs and Herman W. Rannels, Man. Alternates, Harold Van Hoose, Man; Everett H. Starcher, Logan; and Thomas P. Long, Man.

MARION (4)—Delegates, Seigle W. Parks, F. W. Mallamo, Rupert W. Powell and G. Thomas Evans, Fairmont. Alternates, Robert R. Frye, Mannington; and Jesse Ray Tuckwiller, Louis E. Baron and Joseph T. Mallamo, Fairmont.

MARSHALL (2)—Delegates, Andrew J. Barger, Glen Dale; and David Ealy, Moundsville. Alternates, Kenneth J. Allen and Don S. Benson, Moundsville.

MASON (2)—Delegates, Don F. Hatten and J. Berrye Worsham, Pt. Pleasant.

McDOWELL (3)—Delegates, R. H. Edwards, Welch; David J. Skewes, Coalwood; and Stephen Mamick, Welch. Alternates, Dante Castrodale, George L. Fischer and A. J. Villani, Welch.

MERCER (4)—Delegates, Upshur Higginbotham, Charles M. Scott, Wade H. St. Clair, Jr., and John J. Mahood, Bluefield. Alternates, Gordon L. Todd, Jr., Princeton; and Richard O. Rogers, Jr., and W. E. Copenhaver, Bluefield.

MINGO (2)—Delegates, Carl J. Greever and Robert J. Tchou, Williamson. Alternates, W. W. Scott and Frank J. Burian, Williamson.

MONONGALIA (4)—Delegates, George A. Curry, Carl E. Johnson, William G. Klingberg and French R. Miller, Morgantown. Alternates, Robert J. Fleming, Hubert A. Shaffer, Robert Greco and C. T. Thompson, Morgantown.

OHIO (6)—Delegates, Joseph L. Curry, Stephen D. Ward, L. A. Lyon, Charles H. Hiles, R. U. Drinkard and Howard G. Weiler, Wheeling. Alternates, Nime K. Joseph, Harry S. Weeks, Jr., M. D. Reiter, Albert L. Wanner, John M. Moore and E. Lee Jones, Wheeling.

PARKERSBURG ACADEMY (5)—Delegates, S. William Goff, and William E. Gilmore, Parkersburg; Asel P. Hatfield, Harrisville; and Charles F. Whitaker, Jr., Parkersburg. Alternates, Lyle D. Vincent, Logan W. Hovis, Charles H. Barnett and Charles W. Thacker, Parkersburg.

POTOMAC VALLEY (3)—Delegates, Vernon L. Dyer, Petersburg; Charles J. Sites, Franklin; and Harry F. Coffman, Keyser. Alternates, H. Luke Eye, Franklin; and Robert W. Bess, Jr., and P. R. Wilson, Piedmont.

PRESTON (2)—Delgates, Donald P. Brown, Kingwood; and Jerome C. Arnett, Rowlesburg. Alternates, W. Parke Johnson, Jr., Masontown; and William H. Harriman, Jr., Terra Alta.

RALEIGH (5)—Delegates A. Allen Bliss, Warren D. Elliott, John J. Marra, George A. Miller and Forest A. Cornwell, Beckley. Alternates, J. A. Vermeeren, Richard G. Starr, Ross P. Daniel and W. W. McKinney, Beckley.

SUMMERS (2)—Delegates, Buford W. McNeer and James W. Stokes, Hinton. Alternates, A. W. Holmes and Jesse T. Johnson, Hinton.

TAYLOR (2)—Delegates, Paul P. Warden and Herbert N. Shanes, Grafton. Alternates, Charles A. Haislip and R. D. Stout, Grafton.

WETZEL (2)—Delegates, Lemoyne Coffield and Charles P. Watson, New Martinsville. Alternates, T. B. Gordon and Kent M. Hornbrook, New Martinsville.

WYOMING (2)—Delegates, George F. Fordham and Samuel D. Santa Rita, Mullens. Alternates, F. J. Zsoldos, Mullens; and E. M. Wilkinson, Pineville.

Reception Committee

James S. Klumpp, *Chairman*

Charles A. Hoffman
Frank J. Holroyd
J. C. Huffman
Thomas G. Reed
Ray M. Bobbitt
Don S. Benson

Thomas L. Harris
Sobisca S. Hall
Russel Kessel
Charles L. Goodhand
Howard G. Weiler

Charles D. Hershey
A. Kyle Bush
W. W. Strange
Kenneth G. MacDonald
Bernard Zimmermann
Hu C. Myers

Albert C. Esposito
William K. Marple
James T. Spencer
Worthy W. McKinney
Nime K. Joseph
John A. B. Holt

Harry S. Weeks, Jr.
Newman H. Newhouse
W. H. Rardin
Logan W. Hovis
N. W. B. Craythorne

George P. Heffner
George F. Evans
Edmund B. Flink
Thomas J. Holbrook

William E. Gilmore
Edward J. Van Liere
E. Lyle Gage
R. U. Drinkard
W. Fred Richmond

William A. Thornhill, Jr.
Paul C. Revercomb
Richard V. Lynch, Jr.
Pat A. Tuckwiller
A. B. Curry Ellison

Grover C. Hedrick, Jr.
Thomas G. Folsom
Warren D. Leslie
Robert T. Bandi
Henrietta Marquis

Hubert A. Shaffer
Rex Dauphin
Karl J. Myers
Joseph L. Curry
W. Paul Elkins

John T. Chambers
A. J. Villani
Frederick H. Dobbs
Robert T. Brandfass
Paul H. Cope

Official Program
WOMAN'S AUXILIARY
to the
West Virginia State Medical Association
38th Annual Meeting
The Greenbrier
White Sulphur Springs
August 23-25, 1962

WEDNESDAY AFTERNOON
August 22

4:00 P. M.—Pre-Convention Board meeting, (Pierce Room). Mrs. Vernon L. Dyer, President, *presiding.*

9:00 P. M.—First Session of the House of Delegates, State Medical Association. (Chesapeake Hall).

Annual Address of the President, D. E. Greeneltch, M. D., Wheeling. Auxiliary members are invited and urged to attend.

9:45-11:00—Dancing in the Ballroom.

THURSDAY MORNING
August 23

9:00—Formal opening of the 95th Annual Meeting of of the West Virginia State Medical Association.

Address by Lt. General Leonard D. Heaton, Surgeon General of the Army.

All Auxiliary members are invited to attend. (Governor's Hall).

9:45—Formal Opening of the Convention. Mrs. Vernon L. Dyer, President, *presiding.* (Mountaineer Room).

Invocation and Pledge of Loyalty, Mrs. Clark K. Sleeth.

Introduction of Honor Guests.

Introduction of Convention Chairmen, Mrs. L. T. Veach and Mrs. Thomas E. Bess.

Roll Call of Delegates, Mrs. J. A. B. Holt.

Convention Rules of Order, Mrs. D. E. Greeneltch, Parliamentarian.

Treasurer's Report, Mrs. Andrew J. Weaver.

In Memoriam, Mrs. George L. Lemon.

Credentials and Registration, Mrs. Frederick Moomau.

Keynote Address—Mrs. William G. Thuss, President, Woman's Auxiliary to the American Medical Association.

Recommendations from Pre-Convention Board Meeting, Mrs. Vernon L. Dyer.

New Business and Announcements.

Report of Revisions Committee, Mrs. William A. Thornhill, Jr.

Report of Nominating Committee, First Reading, Mrs. Clark K. Sleeth.

Election of 1963 Nominating Committee.

Reports of Officers:

President—Mrs. Vernon L. Dyer.
President-Elect—Mrs. Howard G. Weiler.
First Vice-President—Mrs. John W. Hash.
Second Vice-President—Mrs. L. Dale Simmons.
Third Vice-President—Mrs. Earl S. Phillips.
Fourth Vice-President—Mrs. Lee F. Dobbs.
Treasurer—Mrs. Andrew J. Weaver.
Recording Secretary—Mrs. J. A. B. Holt.
Corresponding Secretary—Mrs. Frederick Moomau.
Parliamentarian—Mrs. D. E. Greeneltch.

Reports of Standing Committees:

AMA-ERF—Mrs. Grover C. Hedrick.
Archives and History—Mrs. N. B. Groves.
By-Laws and Handbook—Mrs. William A. Thornhill, Jr.
Civil Defense and Safety—Mrs. Carter F. Cort.
Community Service—Mrs. Ira Connolly, Jr.
Convention—Mrs. L. T. Veach and Mrs. Thomas E. Bess, Sr.
Editor, State News Bulletin—Mrs. Clark K. Sleeth.
Circulation Manager—Mrs. Hubert A. Shaffer.
Finance—Mrs. Harry E. Beard.
Health Careers—Mrs. C. L. Terlizzi.
Legislation—Mrs. A. C. Chandler.
Members-at-Large—Mrs. Hu C. Myers.
Mental Health—Mrs. Robert Tchou.
National Bulletin—Mrs. William T. Lawson.
Necrology—Mrs. George L. Lemon.
Nutrition and Rural Health—Mrs. Lynwood D. Zinn.
Press and Publicity—Mrs. Joe N. Jarrett.
Program—Mrs. George A. Curry.
Southern Medical Councilor—Mrs. J. C. Huffman.

Presentation of County Presidents:

Boone—Mrs. H. H. Howell.
Cabell—Mrs. Rowland H. Burns.
Central West Virginia—Mrs. Harold D. Almond.
Eastern Panhandle—Mrs. C. Vincent Townsend.
Fayette—Mrs. Thomas C. Sims.
Greenbrier—Mrs. Stuart T. Bray.
Hancock—Mrs. E. M. Clubb, Jr.
Harrison—Mrs. Bernard W. Wilkinson.
Kanawha—Mrs. William R. Rice.
Logan—Mrs. H. W. Rannels.
Marion—Mrs. J. J. Jenkins, Jr.
McDowell—Mrs. H. A. Bracey.
Mercer—Mrs. W. F. Hillier, Jr.
Mingo—Mrs. R. A. Salton.

Monongalia—Mrs. John H. Trotter.

Ohio—Mrs. George M. Kellas.

Potomac Valley—Mrs. Harry E. Coffman.

Preston—Mrs. John W. Trenton.

Raleigh—Mrs. Harry F. Cooper.

Summers—Mrs. Buford W. McNeer, acting representative.

Taylor—Mrs. Herbert N. Shanes.

Wood—Mrs. George Gevas.

Wyoming—Mrs. R. C. Hatfield.

THURSDAY AFTERNOON

2:30-5:00—Bridge Party in the Trellis Lobby.

3:00—Naturalist Tour.
Tour of Arts Colony.
Visit the Exhibits. Exhibit Center open until 5 o'clock.

THURSDAY EVENING

9:45-11:00—Dancing in the Ballroom.

FRIDAY MORNING

August 24

8:00—Past President's Breakfast, Mrs. Clark K. Sleeth, Immediate Past President, *presiding*. (Director's Room).

9:30—Second General Session. Mrs. Vernon L. Dyer, President, *presiding*. (Mountaineer Room).

Invocation and Pledge of Loyalty, Mrs. Robert R. Pittman.

Introduction of Honor Guests.

Roll Call, Mrs. J. A. B. Holt.

Address: "You Are One-Half of One Doctor's Team."—Mr. John W. Pompelli, AMA Field Representative.

Report of Reading Committee, Mrs. P. A. Tuckwiller.

Convention Announcements, Mrs. L. T. Veach.

Report of Woman's Auxiliary to the Student American Medical Association.

Guest Speaker: Mrs. Roy A. Douglass, President, Woman's Auxiliary to the Southern Medical Association.

Reports of Convention Committees:

Finance—Mrs. Harry E. Beard.

Courtesy Resolutions—Mrs. William R. Rice.

Credentials and Registration—Mrs. Frederick Moomau.

Press and Publicity—Mrs. Joe N. Jarrett.

Report of Nominating Committee, Mrs. Clark K. Sleeth, Chairman.

Election of Officers.

Installation of Officers, Mrs. William G. Thuss, President of the Woman's Auxiliary to the American Medical Association.

Presentation of President's Pin and Gavel, Mrs. Vernon L. Dyer.

Presentation of Past President's Pin, Mrs. Clark K. Sleeth.

Inaugural Address—Mrs. Howard G. Weiler.

FRIDAY AFTERNOON

12:30—Luncheon and Fashion Show by Alanson's of The Greenbrier. Mrs. Harry F. Coffman, Chairman of the Fashion Show. (The Crystal Room).

Golf Tournament. Mrs. H. J. Maxwell, Chairman.

Visit the Exhibits. Exhibit Center open until 5 o'clock.

FRIDAY EVENING

9:00—The Barter Players of Abingdon, Virginia.—Presented through the courtesy of the Potomac Valley Medical Society. (Chesapeake Hall). The Players will present a musical comedy entitled "Fantasticks."

SATURDAY MORNING

August 25

10:00—Post-Convention Conference and Board Meeting. Mrs. Howard G. Weiler, President, *presiding*. (Mountaineer Room).

SATURDAY AFTERNOON

3:00—Second and Final Session of the House of Delegates (Theatre).

Address by George M. Fister, M. D., President, American Medical Association.

All Auxiliary members are invited and urged to attend both sessions of the House of Delegates.

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association. (Chesapeake Hall Terrace).

7:30—Presidential Dinner Honoring George M. Fister, M. D., President of the American Medical Association. (Chesapeake Hall).

Speaker: The Rev. Robert P. Varley, Th. D., Rector, St. Peter's Episcopal Church, Salisbury, Maryland. Subject: "Individual Integrity or Social Suicide."

SCIENTIFIC EXHIBITS

(Exhibit Center)

AMERICAN CANCER SOCIETY W. VA. DIVISION, INC.

"Examination of the Colon and Rectum."—The left hand panel is a translucent one divided in four parts depicting areas seen through the sigmoidoscope. Each of the four sections includes two transparencies of the types of lesions that may be found. This panel is lighted sequentially so that the viewers may follow the course of the instrument through the colon to the sigmoid. The right hand panel gives some figures on the incidence of cancer at these sites and the comparative incidence between groups with and without polyps. These figures point up the possibility of cancer of the rectum and colon being 25 times greater in individuals with polyps than in those without polyps.

John H. Yeatts, Executive Director.

A DECADE OF EXPERIENCE WITH ORAL AND PARENTERAL ANTI-INFLAMMATORY STEROIDS IN ALLERGIC RHINITIS

The exhibit describes a decade of experience with oral and parenteral anti-inflammatory steroids in allergic rhinitis. All patients treated with these hormones were considered to be failures in conventional therapy. The steroids used were cortisone, prednisone, prednisolone and dexamethasone. The daily oral dose of these preparations was approximately equivalent to 100 mg. of cortisone. One or another of these preparations was administered for four days and four days was considered a course. The parenteral dose of dexamethasone ranged between 6 and 8 mg. given twice weekly and this, also, was considered a course. Our experience indicates that given in short courses, steroids are effective and devoid of undesirable side effects in allergic rhinitis. Methods and materials, the time required for initial relief and optimum relief and the time of relapse will be illustrated.

Irving W. Schiller, M. D.

DESIGN FOR A DISABILITY DECISION

This exhibit through brief messages and pictures, illuminated in sequence, explains how members of the medical profession cooperate in making effective the provisions of the social security disability program. This cooperation includes: (a) medical participation in the development of medically sound disability evaluation principles through membership in the Medical Advisory Committee; (b) the providing of complete medical reports for patients by attending physicians; and (c) medical participation in determinations of disability by physician members of State agency evaluation teams. The exhibit was prepared by the U. S. Department of Health, Education and Welfare, Social Security Administration, Bureau of Old-Age and Survivors Insurance.

DIVISION OF VOCATIONAL REHABILITATION

This exhibit will feature charts, posters and brochures showing the services provided by the Division of Vocational Rehabilitation to the physically and mentally handicapped citizens of West Virginia.

F. Ray Power, Director.

INTRAVENOUS ARTERIOGRAPHY

Intravenous arteriography was first introduced at the New York Hospital two years ago. The radio-opaque substance is injected simultaneously into both antecubital veins. It flows through the heart, out the aorta and into its branches. The x-ray films are exposed as the radio-opaque substance is traversing the artery under study. The innominate, the subclavians, the common carotids, the cervical portion of the internal and external carotids, the vertebrals, the entire length of the aorta, the renals and the iliacs can all be visualized. Intravenous arteriography is useful in the evaluation of patients with strokes (to rule out obstruction of extracranial arteries), aneurysms and other lesions of the aorta and its major branches, stenoses or occlusion of the main renal arties, and atherosclerosis of the aorta, iliac and femoral arteries.

Robert Alan Keisman, M. D., Hunter S. Neal, M. D., Melvin Myers, M. D., Margaret Gray, R. T., and Eleanor Hoch, R. T.

KANAWHA SPEECH AND HEARING CENTER

This exhibit describes the audiologist's and speech pathologist's assistance to the physician in the evaluation and rehabilitation of a hearing and/or speech problem.

Jess Barton, Jr., Director.

THE NATIONAL FOUNDATION

"Chromosome 21"—This exhibit presents information on Down's Syndrome (Mongolism) which is associated with an overdose of Chromosome 21. This overdose manifests itself in three different ways—standard trisomy, translocation and mosaicism. Standard trisomy occurs in 1:600 births, usually in children born to older women. Children with translocation type of Down's Syndrome are usually born to younger parents, one of whom carries the translocated chromosome 15/21. Mosaicism is very rare and is the result of an error in division of an early embryonic cell. The exhibit includes pictures of patients and karyotypes illustrating each of these three forms. Some clinical aspects—mental retardation, typical facies, hand and foot prints, white blood count and leukemis—are outlined.

OFFICE OF HEALTH MOBILIZATION
W. VA. STATE DEPARTMENT OF HEALTH

Health care and health protection is the joint responsibility of the public and volunteer health care agencies and the private practitioner in all medical and allied disciplines of health care. In a national disaster the survival and recovery of the nation greatly depend upon the health of the surviving population and its ability to re-establish health care and health protection facilities. Medical Self-Help Training and the training for use of Civil Defense Emergency Hospitals are the basic programs in emergency health services. Medical Self-Help Training is designed to better prepare the population for maintaining health and saving lives under survival conditions. The Emergency Hospital Training is to acquaint medical and allied medical personnel with the materials and equipment in the national medical stockpile for their uses in restoring and maintaining health of the surviving population in recovery.

Samuel J. Hawkins, Program Consultant.

THE TEMPORAL BONE BANKS PROGRAM FOR EAR RESEARCH

The Temporal Bone Banks Center, located at the University of Chicago, has prepared a scientific exhibit on inner ear pathology to demonstrate the objectives of its nationwide deafness research program. Jointly sponsored by the American Academy of Ophthalmology and Otolaryngology and the Deafness Research Foundation, the Center seeks temporal bones and brains from documented cases of deafness and dizziness to study the underlying pathology now lacking in these conditions. In the exhibit large transparent color photomicrographs illustrate inner ear pathology in specimens obtained in recent years from various types of deafness. The method of removal and preparation of the specimens is demonstrated by repeating slides.

John R. Lindsay, M. D., and Paul H. Ward, M. D.

WEST VIRGINIA HEART ASSOCIATION

WEST VIRGINIA ASSOCIATION FOR MENTAL HEALTH

"With Your Help the Mentally Ill Can Come Back." This exhibit consists of three units which demonstrate research, treatment, community facilities and rehabilitation of the mentally ill.

Alice Scott Leslie, Executive Director.

WEST VIRGINIA ASSOCIATION OF MEDICAL ASSISTANTS

Members of the Association will distribute literature concerning the objectives of the organization.

W. VA. SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, INC.

The West Virginia Society for Crippled Children and Adults architectural barrier exhibit depicts the disadvantages crippled people have in obtaining access to public buildings. Proper planning and remodeling can overcome these barriers.

Mrs. Jean Harper, Field Representative.

WEST VIRGINIA UNIVERSITY MEDICAL CENTER

WEST VIRGINIA TUBERCULOSIS AND HEALTH ASSOCIATION

RD—Diagnosis and Treatment Exhibit. Read the case history of the x-ray. Diagnose the case, turn to question 1 and try answering it to fit the diagnosis. When the Didak Teaching Machine exposes a question, the physician may write the answer in answer box; if he is not ready to answer, he can push a "knob" which exposes a clue. The physician may then have another opportunity to write an answer in the second question box. If he does not know the answer, he may push the "knob" over to the next stop and the machine will then expose an answer. At this time, the physician will know whether he was correct on the first or second try, or whether he disagrees with the given answer.

Thomas A. Deveny, Jr., Executive Director.

INDUSTRIAL EXHIBITS

(Exhibit Center)

THE BAKER LABORATORIES, INC.
Cleveland, Ohio

Booth 2

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding are on display. Baker representatives will be glad to discuss the benefits of Baker Milk products which provide all the normal dietary requirements plus a reserve for stress situations.

Representatives: Robert J. Porter and Charles A. Greiner.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, New York

Booth 20

You are cordially invited to visit Burroughs Wellcome & Co., (U.S.A.) Inc., booth 20 for the latest information on our products, and the newest developments from the extensive research facilities of Burroughs Wellcome & Co. Of particular interest at this meeting will be our new topical and ophthalmic antibiotic products, as well as our 'Actified-C' Expectorant. Our informed staff welcomes this opportunity to show you these new products.

CAMERON SURGICAL INSTRUMENTS COMPANY
Chicago, Illinois

Booth 9

Cameron Surgical Instruments Company will display its new Electrosurgical Units for hospital use, as well as for modern office surgery. Also showing Suction Coagulation Electrodes, Snares, Electrified Biopsy Forceps, electrically illuminated Ano-Procto-Sigmoidoscopic equipment (distal and proximal), Vaginal Speculae, Otoscope, Mouth Gag, Transilluminators, Gastroscopes, Headlites, Binocular Loupes, Luxo Lamps, etc.

Representative: William E. Mettler.

CARNATION COMPANY
Los Angeles, California

Booth 23

Carnation Company cordially invites you to visit Booth 23 where Medical Representatives will be pleased to welcome members and guests of the West Virginia State Medical Association. Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat and Carnalac are available. Any question pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed.

Representatives: James D. Whittington and Homer L. Altice.

CIBA PHARMACEUTICAL PRODUCTS, INC.
Summit, New Jersey

Booth 8

The Ciba booth features SER-AP-ES. SER-AP-ES is a combination of antihypertensive agents from Ciba research—Serpasil, Apresoline and Esidrix—in a single tablet. SER-AP-ES lowers blood pressure uniformly, consistently and safely while it controls such hypertensive complications and anxiety impaired renal circulation and edema. With SER-AP-ES moderate to severe hypertension can be treated effectively, with greater confidence, and at lower cost to the patient. Ciba representatives will be at the booth to answer medical questions.

Representatives: Robert O. Higham and Marvin K. Ballengee.

THE COCA-COLA COMPANY
Atlanta, Georgia

Booth 43

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Clifton Forge, Inc., and the Coca-Cola Company.

EATON LABORATORIES
Norwich, New York

Booth 30

Our Medical Service Representatives at the Eaton Booth welcome the opportunity to be of service to you. Complete information is available concerning the nitrofurans, The Eaton Medical Film Library, Student AMA Photo Salon and other special services to the profession.

Representatives: T. R. Haught and W. C. Thomas.

ENDO LABORATORIES, INC.
Richmond Hill, New York

Booth 17

Endo Laboratories will present the latest clinical information relating to our products: Coumadin®, Percodan®, Numorphan®.

GEIGY PHARMACEUTICALS
Yonkers, New York

Booth 16

Geigy cordially invites members and guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of inflammation, as well as current concepts in the control of hypertension and edema; depression; obesity, and other disorders, which may be discussed with physicians and representatives in attendance.

HOSPITAL & PHYSICIANS SUPPLY COMPANY
Charleston, West Virginia

Booth 46

You are cordially invited to visit our booth located in space number 46. Our exhibit will consist of the latest in Burdick new Dual-Speed Electrocardiograph, new diagnostic instruments by Welch Allyn, Castle autoclaves, and all types of emergency resuscitation equipment. We sincerely thank you for your patronage this past year, and shall look forward to visiting with you again.

Representatives. L. Keith Kloman, Robert E. Lee Frazier, Robert K. Thacker and Gordon H. Davis.

ELI LILLY AND COMPANY
Indianapolis, Indiana

Booth 44

You are cordially invited to visit the Lilly exhibit located in space number 44. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

Representatives: W. F. Brannon, J. L. Rosenberry and Gregory Gill.

THE S. E. MASSENGILL COMPANY
Bristol, Tennessee

Booth 19

Best wishes from Massengill to the West Virginia State Medical Association for a most successful meeting. Our representatives will welcome the opportunity to discuss products of interest to you. On display will be several Massengill specialty preparations, and literature will be available, should you desire it.

Representative: L. M. Cobb, Jr.

MEAD JOHNSON LABORATORIES
Evansville, Indiana

Booth 21

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and products information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Representatives: John B. Conaway and Rex H. Windham.

MEDICAL ARTS SUPPLY COMPANY
Huntington, West Virginia

Booth 42

We extend a cordial invitation to all of you to visit our exhibit where our representatives will be pleased to show and demonstrate the new items we are showing that we feel will be of interest to you. Be sure to see the "New Pelton Omniclave," the latest development in office autoclaves providing steam and dry sterilization all in one unit.

Representatives: M. L. Clovis and Roy Childers.

MERCK SHARP & DOHME
West Point, Pennsylvania

Booth 13

The theme of the Merck Sharp & Dohme exhibit is "Service to Medicine." One phase features the details of the Merck Sharp & Dohme Postgraduate Program. Another feature includes information on teaching films for use by the profession, and also, lay films that can be utilized to portray the story of medicine to the lay public. The exhibit is concluded with a display of finger-tip files on selected Merck Sharp & Dohme products.

Representatives: M. S. Robertson and J. E. Payne.

MILAN PHARMACEUTICALS, INC.
White Sulphur Springs

Booth 24

Milan Pharmaceuticals of White Sulphur Springs, West Virginia, will display its general line of pharmaceuticals, among these a nonamphetamine product for weight control, APCOL, a chelated iron and trace mineral product for iron anemia, Kellatron, and a new product for capillary fragility, Eldran.

ORTHO PHARMACEUTICAL CORPORATION
Raritan, New Jersey

Booth 28

Welcome to Booth 28 where Ortho is proud to present a complete line of products for the control of conception. Representatives on hand will be pleased to answer your questions on these and our other well-known products.

Representatives: Raymond E. Weekley, Jr., Maynard L. Inman and Richard L. Johnston.

PFIZER LABORATORIES
New York City

Booth 15

Professional Service Representatives from Pfizer Laboratories will be pleased to have you in attendance at their booth to discuss the latest products of Pfizer research.

PLOUGH LABORATORIES, INC.
Memphis, Tennessee

Booth 29

The Plough Laboratories display includes two demonstrations of the unique pharmacological activity of Silain, a gastrointestinal defrothicant. In vitro-Silain breaking the foam which holds much gas-aids in its elimination. In vivo-gastroscopic photographs show Silain's effect on foam in the stomach.

Representatives: Don Ramier and Fred Casey.

WM. P. POYTHRESS & COMPANY, INC.
Richmond, Virginia

Booth 3

A cordial welcome awaits you at the Poythress booth which will feature Bensulfoid Lotion, outstanding and distinctive treatment for acne; Synirin, for pain; and Mudrane, effective, balanced formula for bronchial asthma. Solfoton, Solfoserpine, Panalgesic, and Trocinate will also be featured. Your requests for literature and professional trial supplies of any Poythress products are invited.

Representative: Benjamin B. Kelly.

ROCHE LABORATORIES
Nutley, New Jersey

Booth 31

Taractan—an original development of Roche research for rapid control of agitation associated with anxiety or depression. By providing a greater margin of safety in both acute and chronically disturbed patients, Taractan overcomes many limitations of the phenothiazines.

Representatives: Luther Pratt, Lacy Corbett and John Plymale.

ROSS LABORATORIES
Columbus, Ohio

Booth 6

Ross Laboratories, manufacturer of Similac, features Similac with Iron, supplying 12 mg. of ferrous iron per quart of feeding at no additional cost. Similac With Iron is designed for use when exogenous iron is indicated in infancy to support the usual diet, and to provide prophylaxis against iron depletion starting about the fourth month or 14 pounds. The newest booklet in the Ross Developmental Aids will be on display at the booth.

SANDOZ PHARMACEUTICALS
Hanover, New Jersey

Booth 12

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth 12, where we are featuring Mellaril, Cafergot P-B, Torecan and our brand new product, Sansert. Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. SAUNDERS COMPANY
Philadelphia, Pennsylvania

Booth 45

Hugh McGinn will again be on hand with the complete Saunders' line. New books of special interest, all published since last year's meeting, include: Parsons and Sommers: Gynecology; O'Donoghue: Athletic Injuries; Nealon: Surgical Skills; Lore: Head and Neck Surgery; Novak and Woodruff: Obstetric and Gynecological Pathology; Finneson: Pain; and Wells: Clinical Pathology.

Representative: Hugh J. McGinn.

SCHERING CORPORATION
Bloomfield, New Jersey

Booth 22

Schering Corporation welcomes the members of the West Virginia State Medical Association and cordially invites you to visit the Schering technical exhibit. Products featured will be: Chlor-Trimeton, unsurpassed antihistamine; Naqua, effective oral diuretic—and antihypertensive; and Fulvicin and Advicin, the first combination to meet the requirements for successful athlete's foot therapy.

Representatives: Jack Rogers, John Carpenter and Robert Link.

JULIUS SCHMID, INC.
New York City

Booth 11

An interesting and informative exhibit featuring Immolin Vaginal Cream-Jel for use without a diaphragm; Ramses Flexible Cushioned and Bendex Diaphragms; Ramses Vaginal Jelly; Vagisec Liquid and Vagisec Plus Jelly and Suppositories for vaginal trichomoniasis therapy; and XXXX (Fourex) Skin Condoms, Ramses, Sheik and Sheik Lubricated Rubber Condoms for the control of trichomonal reinfection.

E. R. SQUIBB & SONS
New York City

Booth 25

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed. At booth 25 we will be pleased to present up-to-date information on these advances for your consideration.

Representative: E. Ray.

STATE MEDICAL ASSOCIATION'S GROUP DISABILITY INSURANCE PROGRAM

Booth 32

The administrator of the Group Disability Insurance Program will provide a brochure describing the plan of the West Virginia State Medical Association's Group

Health and Accident and Office Overhead Expense Insurance Programs to visitors at the booth. The fundamental advantage of the group insurance plan is service here in West Virginia. This is an opportunity to meet the administrator—he is the man who will pay your claim.

Representatives: J. Banks Shepherd and A. B. Daniel.

THE STUART COMPANY
Pasadena, California

Booth 26

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be in attendance to answer your questions on new products developed in our new and modern laboratories which have received international acclaim.

Representative: Barry R. Smith.

THERMO-FAX SALES, INC.
Charleston, West Virginia

Booth 27

The Thermo-Fax Copying Products, manufactured by Minnesota Mining and Manufacturing Company, are widely used by the medical profession in preparing bond weight white itemized statements for less than one cent each. The new Model 45 Secretary Copying Machine equipped with Copy-Trol Dial virtually eliminates any wastage of statement paper. This same versatile copying machine will also laminate important documents, prepare project transparencies, and will do many other important jobs in the doctor's office. We cordially invite you to visit our booth and get the latest on these products from 3M research.

Representative: William F. Peters.

WARNER-CHILCOTT LABORATORIES
Morris Plains, New Jersey

Booth 47

Gelusil®—the physician's antacid—for lasting relief of pain and control of gastric acid by neutralization and absorption. The unique dual gel formed by Gelusil protectively coats irritated and eroded mucosa. Gelusil is inherently nonconstipating—contains no laxative. Peritrate®—for the patient with coronary artery disease—with or without angina. Peritrate increases myocardial blood flow and oxygen supply safely—with no significant change in blood pressure, cardiac output or pulse rate.

ANNUAL REPORTS

Committee on Aging

Your Committee on Aging held one meeting this year at the headquarters offices in Charleston. The Chairman, two other members of the Committee and Mr. William H. Lively were present. It was the opinion of the Committee at this meeting that local county societies should have active Committees on Aging which could aid in activities at the local level by fostering, stimulating and urging establishment of nursing homes in their county or counties.

It was further urged that members of the local committees attempt to speak before local clubs and organizations to explain the Kerr-Mills approach to care of the aging, and the fallacy and danger of socialization should King-Anderson type of legislation be enacted.

It was further urged that local county societies try to help in the organization of training programs for registered and practical nurses who would be interested in and care for chronically ill and aging persons.

The Chairman of the Committee attended a meeting on health care of the aged in Chicago, December 15-16, 1961, and reported this meeting by means of an editorial in *The Journal*. Members of the Committee have spoken at meetings of Rotary, Kiwanis and Lions clubs during the year.

The Committee offered its services to the officers of the Association during the troubled times of the attempt at scuttling the MAA program and some members attended the Aircade meeting of the National Chamber of Commerce in Charleston.

Respectfully submitted,

E. Lyle Gage, M. D.,
Chairman.

Bluefield,
June 1, 1962.

AMA-ERF Committee

The American Medical Education Foundation was established in 1951 for the purpose of providing financial assistance to medical schools. The American Medical Research Foundation was established in 1957 for broader purposes, including the provision of financial assistance to medical schools.

Effective January 1, 1962, the programs of AMEF and AMRF were consolidated within the framework of a single Foundation—The American Medical Education and Research Foundation. At the same time, these programs were expanded and a concerted effort made to provide increased financial assistance to medical schools, in addition to financing the other projects of the Foundation.

This Foundation is incorporated under the laws of the State of Illinois as an educational, scientific organization. All contributions to the AMA-Education and Research Foundation are tax deductible under Section 501(c)(3) of the U. S. Internal Revenue Service Code.

The affairs of this Foundation are managed by a Board of Directors elected annually by and from the membership of the Board of Trustees of the American Medical Association.

At the present time, the Foundation is seeking funds to support the following programs:

(1) Unrestricted financial assistance to medical schools.
(2) A medical journalism fellowship program.
(3) A research grants program for medical research workers.
(4) A study of perinatal mortality and morbidity.
(5) A study of continuing medical education.

During 1962, the Foundation will also undertake to raise funds to assist in the financing of medical scholarships and for loans to medical students, as well as to physicians in internships and residencies.

The AMA-ERF seeks financial support from physicians, constituent and component medical societies, the Woman's Auxiliary, philanthropic organizations, business entities, and the general public. Within the limitations of the financial needs of its various projects, the Foundation encourages contributors to designate which project they wish to support and, in the case of financial assistance to medical schools, to designate the specific school which is to receive their contribution.

The success of the Foundation's fund-raising efforts is in good measure dependent upon the voluntary cooperation and support from constituent and component medical societies and their counterpart components of the Woman's Auxiliary. The support of physicians and their wives can best be enlisted through the efforts of these local societies. The effectiveness of this approach is clearly demonstrated by the success of constituent and component society and local auxiliary efforts to raise funds for AMEF in the past.

The fund raising program runs currently with the calender year, starting January 1, and ending December 31, consequently this report is incomplete and will cover only the figures compiled up to this date. West Virginia is credited with 1406 members, from which in 1960, only 174 members contributed $5,222.78. In 1961, 593 members contributed $13,509.07, which was a 300 per cent increase in member-giving, but approximately 150 per cent increase in gifts.

The current reports for 1962 are available only through April, or four months of this year. The average is comparable with 1961. One hundred seventy three

members have contributed $4,386.91. If we can hopefully multiply this by three, for the year, we would have 519 members, contributing $13,160.73. In this report, all contributions have been included, whether or not they were from individual members, component societies, or the Woman's Auxiliary. Individual names have been left out for sake of brevity.

Although your Chairman has put little effort into the cause, I am grateful for the manifested results throughout the State. I feel that every responsible member is cognizant of the program and for what it stands, and it is up to the individual to respond according to his or her personal feeling and ability. I do observe, however, that most members have accepted the suggested voluntary $10 contribution.

May I take this opportunity to express my personal gratitude to each and every contributor, regardless of the gift, and to those folks on the State level, who shoulder the lion's share of the work.

Respectfully submitted,

Earl S. Phillips, M. D.
Chairman.

Wheeling,
May 29, 1962

Cancer Committee

The Cancer Committee of the West Virginia State Medical Association met on November 26, 1961. Last year 2530 West Virginians died from cancer, and this disease continues to rank second as cause of death in our state. Several items were discussed toward improving the control of cancer in West Virginia, and the following conclusions were reached:

The Cancer Committee endorses very strongly the work of the American Cancer Society because cancer information and education at the public level are so important. We are also very pleased with and endorse the work being done by so many interested men and womens clubs in this area. We must continue to help these people as much as we can since early diagnosis and treatment have so much to do with prognosis of and the survival from malignant disease.

The tumor clinics and Division of Cancer Control of the West Virginia State Health Department need added funds to complete their work each year. We still have many West Virginians over and under retirement age who require financial help to care for their malignant disease. It was recommended that the Board of Public Works be informed of this deficiency. Your Chairman discussed this situation with Governor W. W. Barron and Secretary of State Joe F. Burdett. We believe our state government is sympathetic on this point, and funds for the year were increased. However, more money is needed and continued effort must be made to improve this program.

The cytology program throughout the state was discussed, and it is pleasing to note the increased use of the Pap smear test. Your Committee endorses this activity, and we must continue to keep our cancer suspicion index at a high level.

It was recommended that a letter be written to all physicians in West Virginia concerning this point. This letter was mailed on January 19, 1962.

The cancer registry at the state and hospital level was discussed. We should all be proud of our state cancer registry. This facility has been in operation for five years, and approximately 16,000 patients are recorded. All physicians and hospitals in the state are cooperating very well with this program, and your Committee commends all of you for your fine work. We encourage you to use your hospital cancer registry and keep it up to date. As the years roll by a great wealth of information concerning patients who have survived or died from cancer will continue to grow.

Several other areas relative to the above points were reviewed, but need not be mentioned here. Your Committee is most pleased with the cooperation and friendliness we see among those looking at the many-sided problem of cancer.

An effective cancer control program involves many people concerning information, prevention, early diagnosis and treatment. To be successful there must be a high degree of communications and cooperation between those involved at all levels. As we look ahead (1963—Our Centennial Year) there is every good reason to believe West Virginia will move forward in cancer control.

Respectfully submitted,

John T. Jarrett, M. D.,
Chairman.

Charleston,
June 1, 1962.

Committee on Maternal Welfare

The Maternal Welfare Committee of the West Virginia State Medical Association, in conjunction with the Division of Maternal and Child Health of the West Virginia State Health Department, met at the Chancellor Hotel in Parkersburg on March 18, 1962. Those attending the meeting were Dr. Charles L. Goodhand, Chairman, and the following members: Drs. Harold D Almond, Paul H. Cope, C. S. Harrison, Robert W. Liebold, J. Preston Lilly, William S. Herold, and Frederick H. Dobbs, Secretary.

The Division of Maternal and Child Health of the West Virginia State Health Department was represented by William S. Herold, M.D., Assistant Director, Frederick H. Dobbs, M.D., Obstetric Consultant, and Ruth Melber, R. N., Obstetric Nurse Consultant.

The Chairman expresses his appreciation for the splendid cooperation of all members of this committee, for without their valuable assistance in the evaluation of the abstracts and the direction of the long-range program of this specialty the value of this committee would be markedly curtailed. It is recommended that at least one-third of the Committee be retained from year to year, as the experience gained is of much value to the work of the Committee.

The Chairman also expresses appreciation for the splendid cooperation of the interested physicians who

assist in completing the abstracts in the maternal death studies. The excellent response of physicians having maternal deaths speaks well of their trust in the function of the committee, that of improving the standards of obstetric practice among the physicians of our State. The extensive scope of therapy offered the patients in this study is ample evidence of the high standard of obstetric practice and hospital facilities in West Virginia.

Several members of the Committee reported on recent meetings of national and local interest. The West Virginia Obstetrical and Gynecological Society had its annual travel meeting at the University of Louisville School of Medicine, Department of Obstetrics, in Louisville, Kentucky, March 4-6, 1962. The American College of Obstetrics and Gynecology met in Chicago, April 2-4, 1962. The majority of the committee members attended both meetings so the discussions were on common ground, that of recent developments in our specialty.

There was one conference on Maternal Mortality Committees conducted by James F. Donnelly, M. D., Director of Maternal and Child Health, North Carolina State Board of Health, and Anthony Ruppersberg, Jr., M. D., Clinical Assistant Professor of Obstetrics and Gynecology, Ohio State University College of Medicine. Another conference on Lawsuits in Obstetrics and Gynecology by Robert J. McNeil, M. D., of Los Angeles, California, clarified the status of Maternal Mortality Committees in relation to legal responsibility in the study of maternal deaths. Any data accumulated or discussed as abstract material is ruled to be heresay evidence and is not admissible in a court of law.

The Chairman invited discussion on the legal responsibility of the physician in checking the Rh Factor, the blood group and blood type of all prenatal patients and their husbands before labor in the event of a developing Rh incompatibility or an ABO incompatibility. This relatively new concept of physician responsibility is indicated because of the recent numbers of malpractice suits based on patient neglect. The committee agreed that from past experience the time wasted in performing these routine tests could make the difference in fetal survival and it would be the physician's responsibility to perform these tests prenatally and have the results available in case a complication developed. The secretary was instructed to prepare a bulletin on this subject and have it distributed to the physicians in West Virginia who practice obstetrics.

Doctor Herold and Miss Melber reported on the activities of the Division of Maternal and Child Health. Miss Melber completed the survey of all hospitals in West Virginia admitting patients for obstetrical care and has this material in statistical and on data sheet forms which is available to any physician in West Virginia for study and for information. The prenatal and delivery service program was presented. There are nine prenatal and delivery services operating in mostly rural counties with a total patient load of 350 deliveries annually. Six prenatal clinics are located in hospitals serving our centers of population having teaching programs for residents and interns. The number of deliveries in these institutions is not available, but it is many times the number delivered in the rural areas.

Tabulated Analysis of Committee's Work

The following tables contain the tabulated analysis of the work of the committee for the current year and these studies are submitted for the information of and study by the members of the West Virginia State Medical Association.

The latest statistical survey available for West Virginia between maternal deaths and births is for 1960. In that year there were:

Total Births	39,696
Maternal Deaths	12
Maternal Death Rate	.3

MATERNAL DEATHS, JULY 1, 1961—JUNE 30, 1962

I. Classification of Maternal Deaths Reviewed by Committee During the Period of July 1, 1961—June 30, 1962.

Year	*Obstetric*	*Non-Obstetric*
1961-1962	8	3* (Medical)

*1 Hemosiderosis: 1 Intracerebral hemorrhage: 1 Infectious hepatitis with liver failure.

II. Obstetric Deaths by Cause (1961-1962)

Cause of Death	*No.*	*% of Total*
Afibrinogenemia Secondary to Atony	1	12.5
Afibrinogenemia with Massive Hemorrhage (P.P.)	1	12.5
Amniotic Fluid Embolism	1	12.5
Bilateral Cortical Necrosis	1	12.5
Eclampsia	1	12.5
Septic Shock	1	12.5
Acute Septic Shock	1	12.5
Postpartum Hemorrhage	1	12.5
Total	8	100. %

III. Obstetric Death by Preventability (1961-1962)

Classification	*No.*	*% of Total*
Preventable by Physician	3	37.5
Preventable by Consultant	1	12.5
Preventable by Patient	2	25.
Preventable by Patient who submitted to Criminal Abortion	1	12.5
Non-Preventable	1	12.5
Total	8	100. %

IV. Obstetric Deaths by Place of Delivery (1961-1962)

Place	*No.*	*% of Total*
Hospital	7	87.5
Undelivered (Home)	1	12.5
Total	8	100. %

V. Obstetric Deaths by Race (1961-1962)

Race	*No.*	*% of Total*
White	8	100. %

VI. Obstetric Deaths by Age Groups (1961-1962)

Age Groups	*No.*	*% of Total*
15-19	1	12.5
20-24	2	25.
25-29		
30-34	1	12.5
35-39	3	37.5
40-44	1	12.5
Total	8	100. %

VII. Obstetric Deaths by Parity (1961-1962)

Parity	*No.*	*% of Total*
Primipara	1	12.5
1-3	5	62.5
4-6	0	
7 and over	2	25.
Total	8	100. %

VIII. Obstetric Deaths by Weeks of Gestation (1961-1962)

Weeks of Gestation	*No.*	*% of Total*
Less than 28 weeks	2	25.
28-33 weeks	0	
34-39 weeks	3	37.5
40 weeks plus	3	37.5
Total	8	100. %

IX. Obstetric Deaths by Operative Procedure (1961-1962)

Procedure	*Preventable*	*%*	*Non-Preventable*	*%*
Cesarean	1	14.3		
Hysterectomy	1	14.3		
Postpartum Hysterectomy	1	14.3	1	100.
Postpartum Exploratory Laparotomy	1	14.3		
None	3	42.8		
Total	7	100. %	1	100. %

X. Obstetric Deaths by Type of Consultation (1961-1962)

Type of Consultant	*No.*	*% of Total*
Internist	7	Percentages cannot be calculated because some patients were seen by more than one consultant. Only one patient had no consultation (12.5%)
Surgeon	5	
Obstetrician	2	
Urologist	1	
General Practitioner	4	
Resident Physician	1	

XI. Interval Between Delivery and Death (1961-1962)

Time Interval	*No.*	*% of Total*
Under 1 day	5	62.5
1 day - 1 week	1	12.5
1 week plus	1	12.5
Undelivered	1	12.5
Total	8	100. %

XII. Outcome of Pregnancy in Obstetric Deaths (1961-1962)

Type of Outcome	*No.*	*% of Total*
Livebirth—full term	5	50.
Stillbirth—full term	3	30.
Criminal Abortion	1	10.
Undelivered	1	10.
Total	10*	100. %

XIII. Analysis of Obstetric Death Certificates (1961-1962)

Death Certificate Correct and Complete	8	100. %

XIV. Autopsies Done on Obstetric Deaths (1961-1962)

Autopsy Obtained	3	37.5
Autopsy not Obtained	5	62.5
Total	8	100. %

*(2 sets of twins)—1 set, full term stillborns; and 1 set, 1 full term live birth and 1 stillborn.

Definitions

1. *Maternal Death*—The death of any woman dying of any cause whatsoever while pregnant or within six months of the termination of the pregnancy, regardless of the duration of the pregnancy at the time of the termination or the method by which it was terminated.
2. *Direct Obstetric Cause of Death*—A death resulting from complications of the pregnancy itself, to intervention elected or required by the pregnancy or resulting from the chain of events initiated by the complication or the intervention.
3. *Indirect Obstetric Cause of Death*—A death resulting from disease before or developing during pregnancy (not a direct effect of the pregnancy) which was obviously aggravated by the physiological effects of the pregnancy and caused the death.
4. *Non-Related Cause of Death*—A death occurring during pregnancy or within 90 days of its termination from causes not related to the pregnancy nor to its complication or management.
5. *Factors of Preventability (Avoidability)* — Preventability should be judged in an ideal academic sense. This concept involves three assumptions. First, the physician possessed all the knowledge currently available relating to the factors involved in the death. Second, by experience, he had reached a high level of technical ability. Third, he had available to him all the facilities present in a well-organized and properly equipped hospital. Because of the austerity of these criteria, it is more desirable to determine avoidable factors involved in the death, rather than to label the death as preventable. This allows more specific discussion resulting in better maternal care and reduction of obstetric causes of death.
6. *Factors of Responsibility*—Responsibility should be determined whenever possible and assigned as appropriate to the attending physician, consultant, midwife, hospital, patient, or any combination.

Factors

A. *Professional Factors*—These are concerned with cases where there appear shortcomings in diagnosis, judgment, management, and technique, and include failure to recognize the complication or evaluate it properly. They also include instances of injudicious haste, delay or timing of operative intervention, and failure to utilize currently acceptable methods of treatment. Finally, they would include services which were technically inept, and those failures which could have been averted by proper and timely consultation.

B. *Hospital Factors*—These are concerned with facilities, equipment, or personnel which are inadequate. In terms of modern obstetrics the hazards of delivery cannot be met successfully unless the hospital provides, (1) a separate, well-directed maternity section; (2) a blood bank; (3) competent 24-hour anesthesia service; (4) suitable x-ray facilities; and (5) adequate 24-hour laboratory facilities.

C. *Patient Factors*—These should be recognized, but never as an excuse for professional inadequacy.

They are concerned with death resulting from a complication for which there is generally successful treatment but which the patient denied herself by delaying her initial visit to the physician, delaying obtaining medical care after the symptoms were obvious at a layman's level, or finally, by not following the advice and instructions of her physician.

D. *Undetermined Factors*—If because of inadequate evidence a clear-cut decision cannot be made, yet short-comings in care are apparent, it would be preferable to indicate that responsible factors are undetermined. An attempt should be made to determine preventability and to locate the responsible factors.

Analysis of Maternal Deaths

The Committee presents the following conclusions from the analysis of these maternal deaths:

1. Hemorrhage again heads the list causing four of the eight obstetric deaths due to direct obstetric causes. The etiology of the four deaths was afibrinogenemia; one being attributed to postmature syndrome but the common denominator in the other three deaths due to afibrinogenemia was the use of pitocin in the induction or stimulation of labor in which the membranes had already ruptured, or were manually ruptured at the beginning of the induction. There was an additional maternal death in which pitocin was used with membranes ruptured and this resulted in septic shock due to gangrene of the bowel.

   Data from recent literature confirms the relationship between the use of pitocin with ruptured membranes resulting in afibrinogenemia or in various degrees of uterine infection ranging from amnionitis and endometritis to septic shock. The Committee concluded that the use of pitocin with ruptured membranes was to be condemned if regular progressive labor did not ensue within a reasonable time and when that time limit had been reached, then to terminate labor by cesarean section. With progressive labor, the progress of labor should be followed with fibrinogen level determinations to anticipate the development of this serious blood clotting defect, and to institute proper therapy before the terminal hemorrhage begins with the delivery of the placenta.
2. Toxemia of pregnancy caused only one maternal death and this was attributed to patient neglect. The physician was called to the home just as the patient was expiring from eclampsia and he witnessed the last few minutes of her convulsion.
3. Bilateral cortical necrosis was the cause of death in the other case attributed to patient and family neglect. The patient was hospitalized too late to reverse the progressive course of the disease, the etiology of which was endometritis, the result of toxic absorption of decomposing twin pregnancies which had perished in utero.
4. The other case of acute septic shock was the result of a criminal abortion. The patient denied to her death the pregnancy and any interference with a pregnancy even when confronted with a fetus which she passed spontaneously in the hospital. She permitted her family physician to treat her for a mesenteric adenitis, which delayed definitive therapy against a criminal abortion with multiple penetrating traumata to the endocervix.
5. There were three maternal deaths attributed to indirect obstetric causes:
   (1) Hemosiderosis which required eleven hospital admissions during the pregnancy for pulmonary crises which subsided under treatment. She expired on the eighth postpartum day.
   (2) Intracerebral hemorrhage which developed on the first postpartum day and the patient expired on the eighth postpartum day.
   (3) Infectious hepatitis with liver failure, the etiology of which was cirrotic changes in the liver the result of long and frequent indulgence in homemade (moonshine) whiskey.
6. Fifty per cent of maternal deaths were preventable by physician and consultant which is no improvement over our previous rate. With the increased incidence of pitocin induction especially among the physicians who specialize in obstetrics there is little hope that this rate will decrease. It is in this area of practice that the Committee can do its greatest good by keeping our physicians informed of the newer developments in research and by pointing out the deficiencies in practice.

Respectfully submitted,

Charles L. Goodhand, M. D.,
Chairman.

Frederick H. Dobbs, M. D.,
Secretary.

June 15, 1962.

Committee on Medical Economics

The Committee activities during the past year have been largely concerned with the MAA program in West Virginia. The year has been marked with periods of crisis, some real and some produced by artificial and unreal actions, which resulted in unfavorable impressions and publicity over the entire nation.

There also have been periods of relative quiet in mutual understanding of the problems involved, and in plan operations. In the consideration of what has happened to MAA in West Virginia, one must always keep in mind the natal and post-natal attitudes of those public officials who admittedly favor a Social Security approach to the problem.

For three months after our last annual meeting there was relative quiet on the MAA front, with occasional complaints of alleged over-usage of facilities by patients, physicians and hospitals, by alleged non-eligibility for full service benefits of certain patients, and allegations of over-charging by certain physicians who, in effect, assumed the privilege of treating certain MAA patients on an indemnity rather than a service basis.

The first real crisis occurred as of December 1, 1961, when the Commissioner of Welfare announced certain radical changes in the standards for fiscal eligibility, together with drastic cuts in fees to be received by hospitals, pharmacists and physicians. He also demanded that each physician sign a participation agreement of indefinite calendar status as a condition for continued professional participation in the MAA program.

These drastic cuts, combined with certain statistical material later to be proven unrealistic, put West Virginia in magazines and newspapers over the entire country as an example of failure of aged medical care under Kerr-Mills legislation. The Commissioner of Welfare again announced his belief that states could not adequately finance Kerr-Mills programs, and reaffirmed his convictions as to the benefits of a Social Security approach to the problem.

It might be of interest to note the satisfactory monthly financial reports of MAA funds in the latter

months of this fiscal year, as contrasted to the dire forecasts of December and January.

In mid-December 1961 a conference was held between the Governor, the Secretary of State, the Commissioner of Welfare, representatives of the medical profession, and other interested persons. Since October 12, 1960, your Committee had contended that the standards of fiscal eligibility were far too generous for the purposes of the MAA program, but in this conference came the first public admission by the Commissioner of Welfare that our contentions were correct. The Commissioner agreed to consult with representatives of the medical profession, the hospitals and other vendors of services before drafting any future regulations or changes therein. He withdrew his demand for participation agreements, and your representatives again pledged our profession to provide adequate medical care for all senior citizens. These matters were approved by telephone poll of the Council.

Your Committee is of the opinion that some of the responsibility for certain disagreements and maladjustments rightfully belong to the medical profession. At the inception of the MAA program we were handicapped by the lack of advance knowledge or estimation of probable future events in such a new venture. Certain incomplete statistical material was available from state and federal agencies and from insurance vendors. These led us to question the far too liberal standards of fiscal eligibility set forth in October 1960, and finally changed in February 1962 on a realistic basis. The original service fee schedule also was restored.

The period of December 1961 and January 1962 was marked by a cross-fire of charges and counter-charges in all areas of public communication on national and state levels. Because of the lack of a simple monthly recapitulation of allotments and expenditures, reports which had been requested by your Chairman on several occasions, the public, the Legislature, the departments involved, and the program vendors were either erroneously or non-informed as to the true financial status of the MAA program. These events and reports were gleefully accepted by Administration leaders favorable to the Social Security approach, and provided rich fodder for a spate of propaganda which worked immeasurable damage to our approved MAA program on a nationwide level.

However, as eventually established when a realistic financial statement was issued by the Department of Welfare, it was determined that $540,000 would be available each month left in the fiscal year ending June 30, 1962, and the monthly allowance for fiscal 1962-1963 would be some $363,000.

At the Commissioner's request, a joint conference committee, consisting of members of this general committee and one osteopathic physician, was appointed and has met with the Commissioner at monthly intervals, except for June when the Commissioner was not available.

For the first time since the inception of the MAA program in West Virginia we now have available monthly a simple financial statement. The operations for April and May 1962 were well under budgetary limits and indicate an adequate operation of the program in fiscal 1962-1963.

At the time this report is being prepared, the King-Anderson bill has been stalled in the House Ways and Means Committee, and Senatorial proponents had tacked a compromise bill as a rider to a house bill on public welfare. The rider retained Social Security operations and taxation, but provided for inclusion of all persons over 65, with provisions for payment of health services for those senior citizens holding prepaid contracts. The ultimate fate of this and similar legislation will be of utmost interest and importance to every member of our profession.

Respectfully submitted,

James S. Klumpp, M. D.,
Chairman.

Huntington
July 3, 1962.

Committee on Medical Emergencies And Civil Defense

Your Committee was represented on Dr. N. H. Dyer's Advisory Committee of Health Manpower, Plans and Training with the view in mind of acquainting the para-medical groups with their necessary expanded functions in the event of a national emergency. We had two such meetings, the last being on September 20, 1961, in conjunction with the assembling of the Civil Defense Emergency Hospital in South Charleston.

Represented besides the Medical Association and the very able Kanawha County Rescue Squad were the state organizations of the nurses, osteopaths, veterinarians, dentists, pharmacists and technicians. These meetings were quite encouraging as Expanded Function training is a must and quite essentially will have to be carried much further, not only by the physicians but by the above mentioned organizations themselves. However, it is *our* responsibility. Physicians must give this training.

Your Committee served with difficulty due to the wide-spread location of the members. We had one group meeting in Charleston and were pleased with the attendance and interest. We wish to thank those members in attendance. We realize they attended from various distances with considerable inconvenience and their presence was appreciated and heartening.

We spoke to the osteopathic physicians at their state meeting and to the nurses at their state meeting. We also were represented by your Chairman at the Civil Defense Training School in Brooklyn, New York, for further training in civil defense and the course in Medical Self Help.

"Medical Self Help" is a 12 lesson course for the laity covering basic instruction in necessary "know-how" for survival in a fall-out shelter. It covers "Fall-Out and Shelters' through burns, hemorrhage, shock, artificial respiration, etc., to and including emergency childbirth. It is hoped that one member in every family will have taken this course by the end of the

year. We are happy to report we were one of the first in the country to start this course. With the help of our physicians, the Civil Defense and Health Departments, we turned out 19 instructors in the first class. Sadly, however, students for further classes have been woefully lacking since the letup of the Berlin crisis. This instruction could foreseeably save thousands of lives.

Our various component societies throughout the State have been contacted in an attempt to encourage activity in this important field of Civil Defense and Medical Emergencies. Another sad note—only 20 of 28 Societies have appointed a committee or else have failed to heed our request for knowledge of such a committee.

We were privileged to represent our State Association, among 12 others, in Pittsburgh, May 11-12, for the Regional Workshop Session—Region 2 Committee on Disaster Medical Care Council on National Security, American Medical Association. Also, in a small way we were able to help in Prep Pitt V. This was an emergency excercise for the City of Pittsburgh with the handling of simulated casualties at 2 airports and 22 hospitals. Between 16,000 and 18,000 individuals were actually involved and emergency preparedness was magnificient. Some people are prepared.

Our last spastic effort was in conjunction with the annual meeting of the W. Va. Chapter, AAGP, in Charleston, May 25-27, 1962. With the expenditure of considerable effort of a few, we were able to transport and exhibit the Civil Defense Emergency Hospital in the exhibit hall. It was actually shocking to see the numbers who stayed away and didn't even bother to see this hospital—the very men who are charged with assembling and operating this valuable asset in the event of a national emergency!

The AMA has stated it is our duty to look to the health and welfare of our citizens and it is clearly our obligation. It is time we assumed these duties and obligations!

Respectfully submitted,

John A. B. Holt, M. D.,
Chairman.

Charleston,
June 20, 1962.

Committee on Rehabilitation

The Committee on Rehabilitation of the West Virginia State Medical Association has not had a meeting this past year. An attempt to canvass the Committee by letter was carried out with some suggestions being obtained, and during the past year your Chairman attended a meeting of the Council on Occupational Health of the American Medical Association.

At the present time, it would appear that the future concern of the handicapped individual in West Virginia is at a stage where more conclusive planning is needed. Various members have made certain suggestions, and it would appear that some of the problems to be determined are as follows:

(1) It is recommended that certain figures and statistics be obtained if possible to determine how effective our present vocational training has been in this State, and whether this plan should be altered to meet the needs of individuals who are not being helped by the program.

(2) A correlation between efforts at physical restoration and total rehabilitation in vocational training also should be studied and an attempt made to determine what plans in the future should be carried out for examination, approval and proceeding with a program for such individuals.

(3) A committee comprised of individuals from the various specialties should be appointed to conduct a detailed study and, in addition, there should be help from the Social Service Department as well as the Occupational Therapy Department.

(4) At least one other rehabilitation center should be organized in this State, possibly at the West Virginia University Medical Center. This center should be set up on the basis of a complete study of each individual and followed by recommendations to meet his specific needs, both physically, mentally and vocationally.

(5) A Committee on the Handicapped was appointed by the Governor during the past year. An effort should be made to meet with this Committee and to determine their general attitude towards helping such a program and making an effort to obtain sufficient funds to carry it forward within the State of West Virginia.

It is obvious that many of these problems could be carried on by a lay committee but an overall evaluation of many of them by physicians, particularly those trained in specific fields, would be of great help in arriving at conclusions which would be of help in presenting a clearer program and a more efficient attempt to improve the present program in West Virginia.

Respectfully submitted,

Justus C. Pickett, M. D.,
Chairman.

Morgantown,
June 27, 1962.

Syphilis Committee

The Syphilis Committee of the West Virginia State Medical Association reviewed the "Task Force Report" for the purpose of evaluating present efforts to prevent and control syphilis, and to recommend a course of action that will lead to the elimination of syphilis as a public health problem.

The 1961 fiscal year was the second consecutive year in which an increase of over 50 per cent infectious syphilis cases were reported to health authorities in the United States. In our own State we had over 50 per cent increase of infectious syphilis this fiscal year (1962). We lead the nation with first admissions to mental hospitals for all psychoses due to syphilis with 1.2 per 100,000 population.

This mounting evidence over the past few years proves that syphilis again has become a public health hazard. The House Appropriations Committee in its report on the venereal disease appropriation said:

"Syphilis is easily detected and in the early stages treatment is successful and not difficult. This is a disease that ought to be eliminated in the United States . . . The Committee will expect the Public Health Service to have recommendations for an effective program when hearings are held next year."

A Task Force, under the Chairmanship of Dr. Leona Baumgartner, New York City Health Commissioner, was appointed by Dr. Luther L. Terry, Surgeon General, Public Health Service, acting on the recommendation of the Public Health Service Advisory Committee on venereal disease control as a result of a call for action by the House Appropriations Committee.

The members of the Syphilis Committee were of the opinion that greater importance be given to the low titer serologies and that further follow-up be done by having more repeated tests. It has been reported that some states have programs of follow-up of reactive laboratory findings and the results have shown a tremendous increase in the number of reported syphilis cases which provide a wider base of syphilis intelligence. The importance of the reactive serology, even with low titer, was stressed further because something is definitely wrong when a person continues to maintain reactive specimens after several routine tests. It may not even be syphilis but the follow-up of reactive blood tests are important and should not be taken lightly.

It was suggested since more emphasis is to be placed on weakly reactive serologies, it will be necessary to further emphasize the use of TPI or TPCF tests and to make certain that the physicians of the State know the availability of such tests. The TPI test is available to our physicians although there is a certain criteria established by the State Hygienic Laboratory, as this is a very expensive test. The physicians may request a TPI test for their patients by applying to the State Hygienic Laboratory.

It was pointed out that in many instances there is certainly insufficient information being taught in the schools in regard to venereal diseases. The students are very much interested in such a program but either the parents or the educators are not.

Other significant aspects of venereal diseases are that the average practicing physician does not know the modern management of venereal diseases and that all venereal disease cases should be reported by name and not by number. It was suggested that a state law be enacted forcing the physicians to submit the names of the individuals for epidemiological study by the health department to make it more effective for the eradication of the disease.

With the presentation of the overwhelming evidence that infectious syphilis has once again become an urgent public health problem, the Committee recommended that the following be adopted:

(1) Task Force report be adopted with emphasis on its recommendations for eradication of syphilis.

(2) Private physicians take more interest in reactive serologies by a more thorough follow-up of low titer specimens.

(3) Increase the educational program both for the professional and lay groups.

(4) Require all infectious syphilis cases, regardless of reporting source, interviewed for contacts, cluster-tested and re-interview to insure that complete epidemiological process is applied.

(5) Require all laboratories, public or private, including hospital laboratories and blood banks, to report *all* reactive blood specimens to the health department by name.

(6) Increase emphasis and extension of venereal disease education and information programs to reach professional personnel including physicians and nurses.

Respectfully submitted,

N. H. Dyer, M. D., M.P.H.,
Chairman.

Charleston,
June 21, 1962.

WVU Liaison Committee

A meeting of the Liaison Committee was held at the Daniel Boone Hotel in Charleston on January 14, 1962. Seven members were present and six absent. The University was represented by Drs. Clark K. Sleeth and Nicholas W. Fugo, and Mr. Eugene Staples.

Matters discussed concerned the need for more obstetrical patients in the Teaching Hospital, referral of patients, delayed reporting, associate membership in the West Virginia State Medical Association for interns and residents, and sending *The Journal* to interns and residents throughout the State.

Other matters referred to the Committee have been resolved without further meetings.

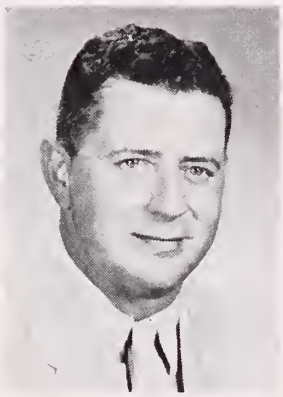
Respectfully submitted,

George F. Evans, M. D.,
Chairman.

Clarksburg,
May 21, 1962.

1962
PROGRAM COMMITTEE

Halvard Wanger, M. D.
Chairman



George P. Heffner, M. D.
Charleston

Charles D. Hershey, M. D.
Wheeling

WVU Medical Center
—News—

FOUR students and eight faculty members of the West Virginia University School of Medicine were recently elected charter members of the new WVU chapter of Alpha Omega Alpha, medical honor society.

Charter members include George H. Nelson of Morgantown and Joseph Ruggiero of Fairmont, both members of the 1962 graduating class; Lowell T. Mouser of Minnehaha Springs in Pocahontas County and Richard D. Richmond of Beckley, both juniors, and the following faculty members:

Dean Clark K. Sleeth; Edward J. Van Liere, Dean Emeritus, and Drs. Harold I. Amory, Nicholas W. Fugo, Robert J. Johnson, Reginald F. Krause, Thomas A. Loftus and Bernard Zimmermann.

Dr. Frederick R. Whittlesey, clinical professor of medicine and one of 19 Medical Center faculty members who earned Alpha Omega Alpha membership at other institutions, was named president of the new chapter.

Other officers are Dr. D. Franklin Milam, first vice president; Dr. Edmund B. Flink, second vice president; Dr. William G. Klingberg, secretary-treasurer; and Dr. John J. Lawless, councillor.

Clinical Instructor in Radiology Named

Dr. Ray A. Harron of Bridgeport has been appointed clinical instructor in radiology at the School of Medicine. He is a member of the Staff of Union Protestant Hospital in Clarksburg, and also practices in Fairmont.

Doctor Harron received his M. D. degree at the New York Medical College and located in Bridgeport in 1961. He is a member of the American College of Radiology, Society of Nuclear Medicine, Harrison County Medical Society, West Virginia State Medical Association and American Medical Association.

A native of Alberta, Canada, Dr. Joseph E. Olivier, has been appointed an instructor in psychiatry. He received his M. D. degree from McGill University in Montreal in 1953.

After serving a rotating internship at St. Paul's Hospital in Vancouver, British Columbia, and practicing medicine for four years, Doctor Olivier served a residency in psychiatry at the State Hospital in Warren, Pennsylvania.

Research Grant

Dr. Walter H. Moran, Jr., instructor in surgery, recently received a $93,604 Research Career Development Award from the United States Public Health Service.

The grant will support Doctor Moran's research in surgical metabolism for the next five years. Much of the knowledge which permits today's open heart, cancer and other types of surgery is based on results of similar research.

• Compiled from material furnished by Howard Lewis, Administrative Assistant to the Vice President, West Virginia University Medical Center, Morgantown, West Virginia.

Four Have Straight-A Averages

Four students in the School of Medicine were among the 51 at WVU who made the Registrar's Honor Roll with straight-A averages during the second semester of the 1961-62 academic year.

David M. Bear of Fairmont achieved a perfect average for the third time and Thomas O. Dotson of Summersville for the second time. The others were Erskine M. Caperton of Mt. Hope and Alexander J. Sabo of Morgantown.

Trends in Graduate Education

A recently published survey of the 1961 graduates of Columbia College discloses that the proportion of those going on to higher study over those terminating at college level is 8.5 to 1.

The professional schools attracted the greater number distributed through medicine, law, engineering business, theology, dentistry, architecture, journalism, and education.

Out of a class of 360, medical study led the list with 94 students enrolled in medical schools throughout the country. Law was close behind with 89, and engineering was third with 33.

Whereas 45 per cent of the class was engaged in the aforementioned professional studies, only 20 per cent were enrolled in graduate schools in the arts and sciences. The most popular studies here were, in order, English 18, history 13, and physics 13.

It would seem that, for the majority, undergraduate experience is the beginning and not the end of higher education. It is encouraging to note that medical study leads all others and that while we have been led to believe that pure science, particularly physics, was making inroads on student attention, this study at least does not show it.

However, the implications are plain for all parents—prepare for a greater educational budget and hope for progeny smart enough to obtain scholarships.—New York State Journal of Medicine.

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1. Hodges, F. T.: *GP* 14:86, Nov., 1956.
2. Guild, B. T.: *Arch. Dermat.* 51:391, June, 1945.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association endorsed in principle the Kennedy Administration's proposed mass immunization program, but urged three important changes. Dr. F. J. L. Blasingame, executive vice president of the AMA, outlined the AMA's position in a letter to Rep. Oren Harris (D., Ark.), chairman of the House Commerce Committee which held hearings on the Administration legislation (H.R. 10541). Doctor Blasingame said:

"The American Medical Association endorses the principle of H.R. 10541 as applied to the four infectious diseases named in the bill—poliomyelitis, diphtheria, whooping cough and tetanus—but urges that: (1) the bill be limited to the four named diseases; (2) the bill be financed as a grant-in-aid program with the states participating on a matching formula basis; and (3) the programs be administered by State Health Departments, preserving the well-established and accepted relationships between the United States Public Health Service and the States in matters pertaining to health."

Committee Accepts AMA Recommendations

The Committee accepted two of the changes proposed by the AMA—that the program be limited to the four specified diseases and administered by State Health Departments. The bill then was passed by the House and sent to the Senate where it promptly received approval of the Senate Labor and Public Welfare Committee.

The bill would authorize federal grants to states and their political subdivisions for "intensive community vaccination" programs against the four diseases during the next three fiscal years. It would authorize $14 million for grants in the first year of operation and $11 million annually for the following two years. The federal funds would be used to purchase vaccine for children under age five, and for salaries and related expenses of the state and local immunization programs.

"Our House of Delegates has on many occasions adopted policy resolutions urging immunization against polio, tetanus, and other communicable diseases for which vaccine exist," Doctor Blasingame said. "Although traditionally it has been the policy of the American Medical Association to urge that the best means of administering vaccines is in the doctor's office, with the family physician vaccinating his patients, we also have recognized that intensive immunization against communicable disease is a public health matter."

The Public Health Service called on physicians to cooperate with community health officials and voluntary health agencies in launching in September a campaign to vaccinate pregnant women, persons suffering chronic debilitating diseases and the general population over age 45 against Asian influenza.

Surgeon General Luther L. Terry of the PHS urged that as many persons in these groups as possible be protected with one shot, or two if they are prescribed, before winter.

Report of Advisory Group

The call for the vaccination campaign was issued after a special advisory group warned that another wave of Asian influenza is due in the United States. The committee said that while accurate predictions are difficult, recent and past patterns of influenza A2 (known as the Asian strain) indicate it probably will occur throughout the nation this winter. The committee said indications were that influenza B would be infrequent.

The committee also recommended that serious consideration be given to immunizing persons in medical and health services, public safety, public utilities, transportation, education and communications fields. Doctor Terry said large scale immunization should be encouraged also in other industries and large institutions where absenteeism is of particular concern.

Previous campaigns included all persons over 65, but the age limit was lowered after study of past outbreaks.

Manufacturers of influenza vaccine were asked to estimate the amount of vaccine that would be needed and to have an adequate supply ready.

Radiation from Nuclear Testing

The Federal Radiation Council said that indications are that radiation received by the average American from nuclear testing is "considerably less than the exposure from natural sources."

But, in a major policy statement, the Council conceded that there is little scientific data to back up this conclusion and that it is difficult to be precise in this field.

"While a considerable body of information has been accumulated on the effects of radiation on animals and man, the possible effects of low doses delivered at low dose rates are insufficiently known to permit firm conclusions about the extremely low exposures resulting from fallout," the Council said in a report.

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Obituaries

ESTA ROSS ALLEN, M. D.

Dr. Esta Ross Allen of Clarksburg, 50, died suddenly at his home in Clarksburg on June 17.

Doctor Allen, who was a native of Lumberport, was born on December 22, 1911, son of Mrs. Clara B. Helmick Allen and the late J. D. Allen. He was graduated from Salem College and received his M. D. degree from the University of Virginia School of Medicine in 1937.

He served his internship at Ohio State University Hospital in Columbus, 1937-38, and had residency training at the U. S. Marine Hospital in Baltimore, 1938-39. He also had postgraduate training at the Mayo Clinic.

He served for 10 years as a consultant at the VA Hospital in Clarksburg and at the time of his death was a clinical assistant professor of medicine at the WVU School of Medicine.

He was certified by the American Board of Internal Medicine and was a member of the American College of Physicians and the American College of Chest Physicians. He was also a member of the Harrison County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his mother, he is also survived by his wife, Mary Eleanor Williams Allen; a daughter, Mrs. Peter H. Neuman of Forest Hills, New York; a son, E. Ross Allen, Jr., a student at West Virginia University; and a brother J. D. Allen, Jr., of Berkley Heights, New Jersey.

* * * *

HARRY C. COBLINER, M. D.

Dr. Harry C. Cobliner, 77, of Charleston, died on July 2 at a hospital in that city.

Doctor Cobliner, who had been a member of the staff at Staats Hospital in Charleston since 1943, was born in Posen, Germany, on November 27, 1884. He received his medical training at the Universities of Heidelberg and Munich and served his internship and residency in Heidelberg. He served as a Captain in the German Army during World War I.

Prior to locating in Charleston, he practiced in Cologne, Germany and New York City. He was a member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

* * * *

JAMES BERNARD DODRILL, M. D.

Dr. James Bernard Dodrill, 82, of Webster Springs, died on June 13 at a hospital in that community.

Doctor Dodrill, who had practiced medicine in the Webster Springs area from 1910 until his retirement several years ago, was born in Birch River, Nicholas

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County, on September 15, 1879, son of the late Martin Van Buren and Mary Dodrill.

He received his M. D. degree from the University of Maryland School of Medicine in 1909, and served an internship at McClung Hospital in Richwood, 1909-10.

He served a term as president of the Central West Virginia Medical Society and was also an honorary member of the West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by two daughters, Mrs. Geraldine Anderson and Miss Bernadine Dodrill, both of Webster Springs; three sisters, two brothers and five grandchildren.

* * * *

CHARLES A. ZELLER, M. D.

Dr. Charles A. Zeller, 63, Director of the West Virginia Department of Mental Health since 1961, died on June 16 while attending a meeting in Williamsburg, Virginia.

Doctor Zeller, who was a native of Factoryville, Pennsylvania, was born on June 22, 1898, son of the late Dr. Charles Adam and Emma H. Zeller. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree in 1927 from the University of Buffalo School of Medicine. He served an internship at Scranton State Hospital, 1927-28.

Doctor Zeller served as Director of the Michigan Department of Mental Health from 1945 to 1947. He resigned that position to become Director of the Indiana Council of Mental Health, a post he held until he was appointed superintendent of Weston State Hospital in 1949. He accepted appointment as Chief of Psychiatry at the VA Hospital in Clarksburg in 1951, and in 1958 accepted a similar position at the Southwestern State Hospital in Marion, Virginia.

Doctor Zeller remained at Marion until June, 1960, at which time he returned to Weston as superintendent. He was named by Governor W. W. Barron as Director of the State Department of Mental Health in January, 1961.

He was a former member of the Central West Virginia Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a daughter, Mrs. Joseph Morton of Bridgeport; a son, Charles A. Zeller, III, of Charleston; two sisters and three grandchildren.

Health Insurance Coverage

More than 135 million Americans—74 per cent of the civilian population—had some form of health insurance at the end of 1961, according to the Health Insurance Council in reporting on its 16th annual survey of the extent of voluntary health insurance coverage in the United States.

The Council said both the number of persons covered, and the amount of benefits paid by health insurance reached new highs last year.

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*R. V. Ford: Cur. Ther. Research, 2:51, 1960.

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County Societies

BARBOUR-RANDOLPH-TUCKER

Mr. D. S. Heeschen, acting director of the National Radio Astronomy Observatory at Green Bank, was guest speaker at a banquet session of the 13th Annual Postgraduate Session of the Barbour-Randolph-Tucker Medical Society on June 21 at the Elks Country Club near Elkins.

In the address, he described the formation of the universe and reported on the recent advancements of the radio telescope. More than 60 persons attended the banquet which was preceded by a social hour.

The morning was devoted to a golf tournament and the afternoon to a scientific session. The speakers and their subjects were:

Mary DeWitt Pettit, M. D., Professor of Gynecology, Woman's Medical College of Pennsylvania, "The County Medical Society's Role in Preventative Medicine, Especially Cancer Protection."

Bertram R. Girdany, M. D., Professor of Radiology, University of Pittsburgh School of Medicine, "Obstructive Lesions of the GI Tract in Infancy."

Wayne H. Borges, M. D., Professor of Research, University of Pittsburgh School of Medicine, "Clinical Application of Recent Advances in Genetics."

Herbert E. Warden, M. D., Associate Professor of Surgery, West Virginia University School of Medicine, "Traumatic Injuries of the Chest."—A. Kyle Bush, M. D., Secretary.

* * * *

CABELL

Dr. George E. Ruff of Philadelphia, chief psychiatrist for "Project Mercury," was the guest speaker at the regular monthly meeting of the Cabell County Medical Society held on June 14 at the Hotel Frederick in Huntington.

Doctor Ruff, assistant professor of psychiatry at the University of Pennsylvania, gave an interesting and stimulating talk on the United States space program.

A social hour preceded the dinner which was attended by 40 members and 26 wives. The formal meeting was called to order by Dr. Jack Leckie, president elect.—W. L. Neal, M. D., Secretary.

* * * *

MONONGALIA

Dr. J. Speed Rogers of Wheeling presented a paper on "Common Neurological Problems" before the regular monthly meeting of the Monongalia County Medical Society in Morgantown on June 5.

Dr. C. Truman Thompson, the president, appointed a liaison committee to the West Virginia University School of Medicine. The committee is composed of Dr. E. F. Heiskell, Jr., chairman, and Drs. D. Franklin Milam, Carl H. Cather, Jr., and Robert Greco.

Dr. Dean Roy Goplerud of the Obstetrics and Gynecology service at the School of Medicine was

elected to membership in the Society.—George A. Curry, M. D., Secretary.

* * * *

RALEIGH

Dr. D. E. Greeneltch of Wheeling, President of the West Virginia State Medical Association, was the guest speaker at a father-son banquet sponsored by the Raleigh County Medical Society and held at the El Chico Restaurant in Beckley on June 21.

Doctor Greeneltch discussed the "Future of Medicine" and he also outlined the position of the state and national organizations in regard to legislation now pending in Congress.

Dr. John A. Hedrick, the president, presided at the meeting.

How to Judge the Quality of a Drug

There is no person alive who can take a bottle of pills, look at them, feel them, smell them and taste them and tell you whether or not they are of high quality. We all know that most people can pretty well determine the quality of textiles, and experts can tell exactly what the quality is by using ordinary senses. This is not so with drugs. I repeat the only way you can reasonably judge the quality of a drug is by relying on the reputation of the name on the label.—Joseph E. Snyder, M. D., Assistant Vice President, New York Presbyterian Hospital, to American Hospital Association.

Book Reviews

LOWER DIGESTIVE TRACT—By Frank H. Netter, M. D. Part II of Volume 3, Digestive System, The Ciba Collection of Medical Illustrations. Pp. 243, with numerous color illustrations. Ciba Pharmaceuticals, Inc., Summit New Jersey. 1962. Price $15.00.

This is a beautiful book. This is a valuable book. This is a book that will not go out of date. This is a book that the student, practitioner and specialist will enjoy and cherish and refer to constantly.

The Ciba Pharmaceutical Company is to be congratulated on this latest addition to its collection of educational material for the medical and allied professions. This book is available at cost and is one of the best bargains this reviewer has ever seen.

The beautiful illustrations by that peer of medical artists, Frank H. Netter, M. D., are on every page. His excellent work is well known to all of us. There is a section on embryology and the gross and microscopic anatomy of the abdomen and lower digestive tract are beautifully covered. The physiology and the pharmacology of the lower digestive tract are discussed and illustrated. Diseases of the lower digestive tract are illustrated. Hernias are thoroughly illustrated. Surgical pathology and surgical technique are in evi-

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dence. There is an excellent section on parasitic diseases.

If ever there were a medical text that proved the axiom that one picture is worth ten thousands words, this is it. There is an impressive list of contributors and consultants who collaborated to place the stamp of authority on this volume. At the end of the volume there is an excellent list of references which indicate the scholarly research which has gone into the preparation of this masterpiece. There is an excellent subject index.

It is evident that this series of volumes that the Ciba Pharmaceutical Company has and is making available will become "classics" in medical literature.—Joseph P. Seltzer, M. D.

* * * *

PROBLEMS IN SURGERY—By Frank Glenn, M. D., Lewis Atterbury Stimson Professor of Surgery, Cornell University Medical College, New York City; and edited by George E. Wantz, Jr., M. D., Assistant Professor of Clinical Surgery, Cornell University Medical College, New York City. Pp. 512. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis, Missouri. 1961. Price $16.50.

A most refreshing approach to surgery. The cases presented are all actual problems which were discussed by the Department of Surgery of The New York Hospital—Cornell Medical Center. This text can be used as a reference book, an aid to teaching the house staff in community hospitals and a most valuable volume for hospital libraries.

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* * * *

ATLAS OF EYE SURGERY—By R. Townley Paton, M. D., Surgeon-Director, Manhattan Eye, Ear, and Throat Hospital; Byron Smith, M. D., Surgeon-Director, Department of Plastic Surgery, Manhattan Eye, Ear, and Throat Hospital; and Herbert M. Katzin, M. D., Director, Eye Bank Laboratory, Attending Surgeon, Manhattan Eye, Ear, and Throat Hospital. Daisy Stilwell, Illustrator. Second Edition. 1962. McGraw-Hill Book Company, Inc.: New York, Toronto and London. Price $25.00.

This second edition of the Atlas of Eye Surgery is different from the first, mainly in that there is an additional section on plastic surgery by Byron Smith, M. D.

In the Preface the authors indicate the book is intended mainly for residents in ophthalmology. As the title implies, the book does not discuss principles or ideas in surgery, it presents detailed drawings of various procedures. The drawings themselves are well

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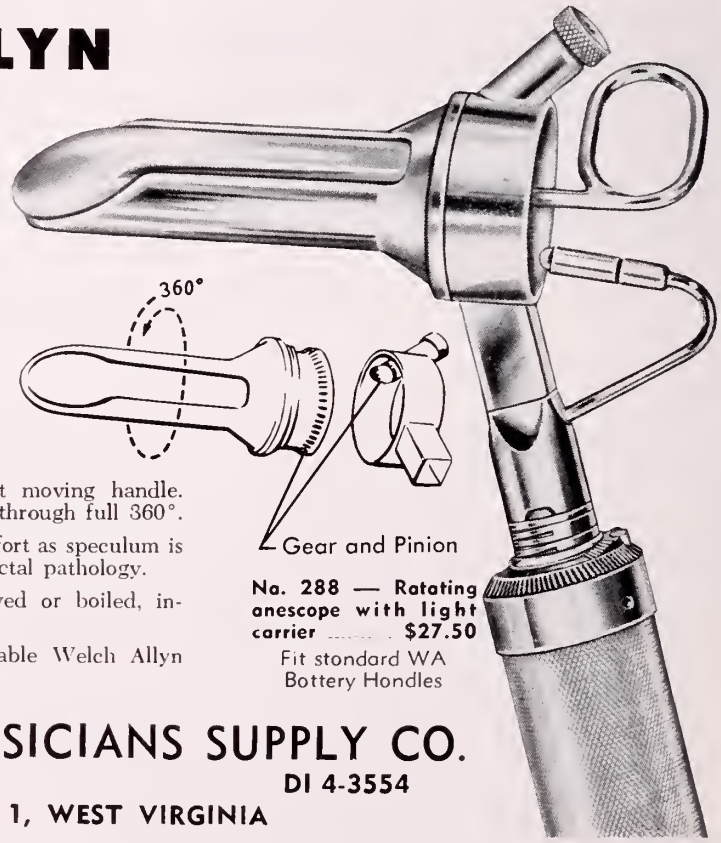

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done; however, they are without color. Whether color would be worth the additional cost is a good question. Other surgical texts may have drawings which appear to be superior but certainly these drawings accomplish their purpose of conveying the idea.

In Part I many of the common surgical procedures in ophthalmology are described. There is a description of the use of alphachymotrypsin, which is a recent technique.

In the section on retinal detachment the later procedures, such as the use of silocone, are not described. This is a shortcoming. On page 114 the authors use a statement, "using the left hand the surgeon introduces the capsule forceps." I do not see the reason for saying the left hand and this might very well be misleading, especially to a beginner. Each man must use the hand which suits him best in this all important maneuver. I think it would be better to use the expression, "the capsule forceps is introduced into the anterior chamber."

The section on plastic surgery is unusual in many respects. First of all, we do not have short inadequate descriptions of many procedures with proper names attached. Obviously, Doctor Smith only presents those procedures which he uses himself and with which he has had wide experience. Since only a few procedures are described they are given excellent treatment.

The anatomic diagrams are excellent and the diagramatic presentation of the anatomy of the upper lid accompanying the operation for levator resection is unusually so.

On page 298 there are two illustrations which show a mistake. The adhesive tape is plastered right on the eyebrow in two instances and I think we all realize this is poor technique.

The average ophthalmologist will find he has spent his money well after purchasing this book. He will also notice Part II of the book will be used much more than Part I.—Alfred J. Magee, M. D.

Books Received

THE IMMUNOLOGY OF RHEUMATISM—By Jerzy B. Kwapinski, M. D., Head of the Subdepartment of Microbiology, University of New England, Australia; and Marshall L. Snyder, Ph.D., Professor of Bacteriology, The Dental School of the University of Oregon, Portland. Pp. 255. Appleton-Century-Crofts, 34 West 33rd Street, New York 1, New York. 1962. Price $9.00.

* * * *

CARCINOMA OF THE CERVIX—By John B. Graham, M. D., Chief Gynecologist, Rosewell Park Memorial Institute; Associate Professor of Gynecology, University of Buffalo Medical School; Luciano S. J. Sotto, M. D., Consultant in Gynecology, Philippine General Hospital; Instructor in Gynecology, University of the Philippines College of Medicine; and Frank P. Paloucek, M. D., Attending Gynecologist, Roswell Park Memorial Institute; Instructor in Gynecology, University of Buffalo Medical School. Pp. 487, with numerous illustrations. Philadelphia and London: W. B. Saunders Company. 1962. Price $14.00.

* * * *

GENERAL PATHOLOGY—An English import based on Lectures delivered at the Sir William Dunn School of Pathology, University of Oxford, and edited by Sir Howard Florey, Professor of Pathology. Pp. 1104. Third Edition. Phil-

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adelphia and London: W. B. Saunders Company. 1962. Price $22.00.

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DISSEMINATION OF CANCER (Prevention and Therapy)—By Warren H. Cole, M. D., F.A.C.S.; Gerald O. McDonald, M.S., M. D., F.A.C.S.; Stuart S. Roberts, M.S., M. D.; and Harry W. Southwick, M. D., F.A.C.S. Pp. 462, with numerous illustrations. Appleton-Century-Crofts, Inc., New York. 1961.

* * * *

MODERN CONCEPTS OF HOSPITAL ADMINISTRATION—Edited by Joseph Karlton Owens, B.S., M.S., Ph.D., Specialist in Hospital Administration, Louis Block and Associates, Inc., Silver Spring, Maryland; with the coordinative assistance of Robert K. Eisleben, B. A., M.A., Assistant Administrator of Little Company of Mary Hospital. Pp. 823, with illustrations. Philadelphia and London: W. B. Saunders Company. 1962. Price $16.00.

* * * *

PRIMER OF CLINICAL MEASUREMENT OF BLOOD PRESSURE—By George E. Burch, M. D., Henderson Professor of Medicine, Tulane University School of Medicine, New Orleans; and Nicholas P. DePasquale, M. D., Instructor in Medicine, Tulane University School of Medicine, New Orleans. Pp. 141, with illustrations. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Mo. 1962. Price $5.50.

* * * *

CIBA FOUNDATION SYMPOSIUM ON TUMOUR VIRUSES OF MURINE ORIGIN—Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., with Maeve O'Connor, B.A. Pp. 441, with 72 illustrations. Little, Brown and Company, Boston, Massachusetts. 1962. Price $10.75.

* * * *

CURRENT DIAGNOSIS AND TREATMENT—By Henry Brainerd, M. D., Professor of Medicine and Chairman Department of Medicine, University of California School of Medicine, and Physician-in-Chief, University of California Hospitals, San Francisco; Sheldon Margen, M. D., Research Biochemist, Department of Biochemistry, University of California School of Medicine, San Francisco; and Milton J. Chatton, M. D., Assistant Clinical Professor of Medicine, University of California, San Francisco, and Stanford University Schools of Medicine, Palo Alto, and Geriatric Consultant, Palo Alto Medical Clinic. Pp. 758. Lange Medical Publications, P. O. Box 1215, Los Altos, California. 1962. Price $8.50.

* * * *

PSYCHOLOGICAL DEVELOPMENTS IN HEALTH AND DISEASE—By George L. Engel, M. D., Professor of Psychiatry and Associate Professor of Medicine, The University of Rochester School of Medicine and Dentistry. Pp. 435. W. B. Saunders Company: Philadelphia and London. 1962. Price $7.50.

Hope for New Steroidal Agents

During the last eight years much knowledge has been gained regarding the effects of chemical alterations on the physiologic properties of steroids.

It is hoped that the pharmaceutical industry will continue to devise and test new modified steroidal compounds as it seems reasonable to expect, as more information regarding structure-function relationships is accumulated, that chemists may be able to create anti-inflammatory steroidal agents which are more efficient and safer than those that are now available.

It would indeed be a severe blow to progress of medical research if legislation is approved that would discourage continued efforts to modify the molecular structures of steroids and to impede the introduction of new drugs that may result from such effort.—Edward B. Boland, M. D., University of Southern California School of Medicine, to Senate Subcommittee on Antitrust and Monopoly.

SEPTEMBER
1962

Vol. 59 No. 9

The
WEST VIRGINIA
Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 343-4607.

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The West Virginia Medical Journal

September, 1962 Vol. 58, No. 9

Symposium on Allergic And Related Pulmonary Diseases
Moderator: Merle S. Scherr, M. D.
Charleston, W. Va.

A Brief Review of Drug Therapy In Bronchial Asthma*

Irving W. Schiller, M. D.

The years elapsing since the end of World War II have been marked by interesting developments in the treatment of bronchial asthma, particularly that phase of treatment involving the use of drugs. With the addition to the list of possible chemical mediators such as heparin, serotonin, bradykinin and "slow reacting substance," along with histamine and acetylcholine, our understanding of the mechanism and pathogenesis of asthma has increased although, admittedly, ever so slightly. Because asthma frequently involves a multiplicity of etiologic and complicating factors, all of which vary from patient to patient, the problem is vexing and management of the disease extremely challenging.

Treatment in General

In general, the treatment of asthma calls for the identification of offending allergens and their subsequent avoidance. Elimination or complete avoidance of the implicated agent or agents often produces spectacular results. When this is not feasible, injection therapy with specific allergenic extract is necessary to reduce bronchial reactivity and to relieve partially or wholly the manifestations of the disease. Since the large majority of patients have multiple sensitivities and frequently have well-established "reactive bronchial trees" that are readily "triggered" by nonspecific factors (respiratory infection, weather changes, chemical fumes and emotions), day to day management of bronchial asthma requires, in addition, the full application of pharmaceutical therapy. Admittedly, this approach may prove to furnish only a temporary respite. Specific treatment ("desensitization," "hyposensitization") of asthma is not to be minimized where study indicates such need, but discussion of this aspect is beyond the scope of this paper.

The purpose of this report is two-fold. First, an attempt will be made to appraise briefly certain broad categories of drugs employed in asthma therapy. Second, because of the resurgence of interest in newer theophylline-bronchodilator preparations, the results of a clinical trial in patients with asthma who received a new sustained acting theophylline bronchodilator compound, WC-961*, will be dealt with in detail in Section II.

The Author

- **Irving W. Schiller, M. D., Associate Clinical Professor of Medicine, Tufts University School of Medicine, Boston, Mass.; and Co-Physician-in-Chief, Allergy Clinic, Boston Dispensary-New England Medical Center.**

*Drs. Irving W. Schiller of Boston, Gustav J. Beck of New York City and William A. Hopkins of Atlanta participated in a Symposium on Allergic and Related Pulmonary Diseases presented in connection with the Fifth Annual Meeting of the West Virginia State Society of Allergy, held during the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25, 1962.

Dr. Merle S. Scherr of Charleston, Secretary of the Society, served as Moderator.

Submitted to the Publication Committee, May 16, 1962.

*Provided by Warner-Chilcott Laboratories Division, Morris Plains, New Jersey, and available as Tedral SA®.

The principles of therapy ordinarily followed are applicable to drugs used in the management of asthma; these include factors related to dosage and route and time of administration. A determinant of drug effectiveness that may be overlooked concerns the potential responsiveness of the patient. For example, the respiratory distress and marked reduction in pulmonary function observed in asthmatic patients may be remarkably reversed with the application of the proper bronchodilator medication, in sharp contrast to the result seen in patients with identical symptoms associated with obstructive pulmonary emphysema.[1] In other words, the desired improvement following intensive drug therapy will not be forthcoming where reversibility is not to be expected and where the underlying pathology is such that it precludes drug action.

Because patients often are seen in the midst of an asthmatic attack, palliative treatment must be employed initially. As soon as possible thereafter, and prior to investigating the role allergy may be playing, all other causes of obstructive pulmonary disease should be considered. When possible, tests of pulmonary function should be employed, since their results provide not only useful diagnostic information but are of value also as guides for selecting appropriate therapy.[2]

Introduction

The Moderator

We are proud to present today, at this Fifth Annual Meeting of the West Virginia State Society of Allergy, a panel on Allergic and Related Pulmonary Diseases which will demonstrate a multi-disciplinary approach to the management of a difficult and somewhat confusing group of diseases.

This "multi-disciplinary approach" will present the aspects of allergic and related pulmonary diseases as viewed by an allergist, a medical specialist in diseases of the chest and allergies, and by a cardiothoracic surgeon who has had much experience in both medical and surgical lung diseases. It is felt that the presentation of one viewpoint concerning a disease or a group of diseases will frequently leave the audience with a feeling that this problem may be approached in only one manner. It is hoped that today's presentation will demonstrate that the best therapeutic results are obtained only when the tools of all the medical specialties are used to their fullest extent in a truly multi-disciplinary fashion.

It also is the hope of the West Virginia State Society of Allergy that today's presentation will offer a better understanding of the subject which will lead to better management of patients suffering with pulmonary disease.

When drug therapy is initiated or when changes in medication are made, cooperation and sense of security can be enhanced by telling the patient what to expect from therapy. This includes the expected time of onset of activity of the drug, its probable duration of action and the nature and severity of side effects that may ensue. The medication to be administered depends largely on the severity of the case, the duration of symptoms, the progression of the illness, results obtained with previous medication and the general status of the patient.

The Bronchodilators

The adrenergic drugs (ephedrine, epinephrine and their analogues) and the methylated xanthines (theophylline and its salts) are potent and valuable bronchodilators, and continue to be the mainstay of therapy in asthma.[3] Mild to moderate attacks of asthma are readily relieved by oral ephedrine in a dose of 25 mg. or less, which may be repeated every three or four hours, as needed. More often than not, aqueous nebulized epinephrine 1:100, or isoproterenol 1:200, is added to the regimen. Two to four inhalations of either of these solutions every three or four hours, or less, usually are sufficient. Patients should be cautioned against their indiscriminate use, since these nebulized solutions may give rise to severe palpitation and nervousness. For the acute attack of asthma, epinephrine 1:1,000 administered subcutaneously remains the most effective drug. It must be used conservatively in patients who may have cardiovascular disease, particularly those in the older age group. The dose varies considerably, the range for adults being 0.20 to 0.40 cc.; smaller amounts should be given to children. Overdosage or administering epinephrine intravenously may produce alarming systemic effects. When the central nervous stimulating effects of the adrenergic drugs are discomforting, antihistamines may be administered simultaneously, with considerable success. Interestingly enough, antihistamines *per se* are of little value in treating the asthmatic patient. The combination of antihistaminic and adrenergic drugs, however, appears to enhance the activity of the latter.[4, 5]

Role of Iodides

Iodides, commonly prescribed as a saturated solution of potassium iodide, are well-established agents for thinning and for loosening inspissated bronchial secretions that are so characteristic of asthma. The usual adult dose is ten to fifteen drops three times a day, taken with liberal quantities of fluid. Such therapy is quite salutary, particularly when asthma is of mild or moderate

severity. Skin eruptions, swollen parotid and submaxillary glands, and fever may make their appearance in the course of treatment, in which case the iodides should be discontinued.

Intermittent positive-pressure breathing therapy with isoproterenol, with or without detergents, has not been helpful in our experience. Likewise, postural drainage has not been helpful.

When to Hospitalize

When the above measures fail and asthma becomes intractable (status asthmaticus), hospitalization is essential. These patients usually are exhausted, over-medicated and dehydrated, and it must be assumed that they have hypoxia and possible carbon dioxide retention.

As soon as possible after admission, an intravenous infusion consisting of aminophylline (0.5 Gm.) and 1 cc. of epinephrine (1:1,000) in 1,000 cc. of water with 5 per cent glucose should be administered, the procedure to be completed in two to three hours. During the first twenty-four hours, it may be repeated every eight hours. Since status asthmaticus frequently is complicated by respiratory infection (usually *Haemophilus influenzae*, beta hemolytic streptococcus or pneumococcus), appropriate treatment with antibiotics is required. Penicillin should be avoided, if possible, because of the asthmatic patients' high degree of sensitivity to this antibiotic. When oxygen is administered because of hypoxia, awareness of its possible adverse effects is essential, particularly when respiratory acidosis is present.[6] Considerable improvement may be expected within a few days when the above regimen is followed, after which residual symptoms are readily controlled with adrenergic preparations or xanthine derivatives, or both.

Sedation Contraindicated

In status asthmaticus the temptation is great to administer sedatives and opiates in sufficient dosage to relieve apprehension and induce rest. Care must be taken, however, to avoid further depression of the respiratory center or to interfere with the cough reflex. The patient already may have difficulty in eliminating carbon dioxide and any decrease in ventilation engendered by heavy sedation may further reduce the disposal of this gas. As a result, severe respiratory acidosis may ensue and the patient may have a fatal exitus. When required, however, the sedative of choice in our clinic is chloral hydrate, given in capsule form in a dose of 0.5 to 1.0 Gm. at bedtime.

Steroids Indicated

When these conservative measures prove inadequate, treatment with one or another of the anti-inflammatory steroids (hereinafter referred to as steroids) should be considered, since these are the most effective and at times the most dramatic of all agents for the control of asthma. The effect of steroids may not be evident for hours, hence they should not be depended upon as a sole measure for the relief of intractable asthma. The steroids may be given parenterally, but the oral route is preferable when the patient is able to take medication in this manner.

During the first twenty-four hours, the dose should be in the range of 300-500 mg. of cortisone (or equivalent doses of other steroids) given orally or intramuscularly in divided doses. Relief of symptoms should be evident within eight to twelve hours, or less. A similar schedule may be maintained for the following twenty-four to thirty-six hours, with a subsequent step-wise reduction of dosage, allowing fourteen to twenty-one days for complete withdrawal. This greatly minimizes the possibility of adrenal crises or a flare-up in asthmatic symptoms. In certain cases, long-term steroid therapy is required because the disease is life-threatening or because patients can not tolerate the severe incapacity that follows the reduction or cessation of a course of steroids. Patients must be followed carefully to minimize the undesirable effects encountered in long-term steroid therapy.[7]

Section II
Oral Theophylline

Until quite recently, the bronchodilator activity of oral theophylline and its salts has not been available to the clinician in full therapeutic measure. The administration of this compound has been definitely circumscribed for the simple reason that when given orally in therapeutic amounts, it caused very disagreeable side effects, particularly nausea. As a rectal solution or suppository, in addition to the obvious disadvantage, absorption of theophylline has proved erratic; its administration intravenously as a soluble salt (aminophylline), though most efficacious, has definite limitations.

With the development of water-alcohol theophylline preparations, one of which contains glyceryl guaiacolate (Quibron®*), a preparation with which we have had considerable experience and success,[8-10] many of the objections to oral theophylline were overcome.

More recently, a two-layered tablet was designed, in which waxy vehicles were used to control the release rate of its active ingredients, theophylline, ephedrine and phenobarbital. Thus, the formulation of this tablet permitted a therapeutic amount of theophylline (90 mg.) and

*Mead Johnson Laboratories.

ephedrine to become available within thirty minutes after its administration; an identical amount of theophylline was released slowly thereafter for at least 4 hours or more to provide adequate bronchodilatation for 10 hours. Earlier experience indicated excellent patient tolerance of this sustained release tablet (Each tablet contained theophylline, 180 mg., ephedrine hydrochloride, 48 mg. and phenobarbital, 25 mg.).

Study of Cases

A study of the effectiveness of this new preparation, WC-961, was undertaken in fifty patients with bronchial asthma in the period from March to December, 1961.

Fifteen females and thirty-five males with perennial asthma, ranging in age from 14 years to 69 years, were selected for study. All were ambulatory, and were selected from private practice and from the Allergy Clinic of the Boston Dispensary; none with status asthmaticus was selected. All patients were experiencing asthmatic symptoms and were undergoing "desensitization" therapy. Bronchodilator drugs other than the drug under trial were omitted in all cases; steroid or antibiotic therapy, or both, were continued in three patients. Chest examinations and tests of pulmonary function were made frequently.

The severity of asthma in each case was classified as follows: Mild: Little or no interference with daily activity or sleep and prompt symptomatic response whenever bronchodilator therapy needed (11 patients); Moderate: Partial disturbance of daily activity and sleep with bronchodilator medication required several days a week (17 patients); Severe: Symptoms interfering with work or sleep, or both; intensive daily bronchodilator therapy required (22 patients).

A control or standard reference drug-response was determined in each patient by employing a non-sustained-acting preparation which contained similar ingredients (Each tablet contained theophylline, 130 mg., ephedrine hydrochloride, 24 mg., and phenobarbital, 8 mg.). Patients were instructed to take one tablet every four hours, as needed, for relief of symptoms. After three to seven weeks, the perceived effectiveness of the control medication for each patient was scored according to the response obtained. Following this, patients were switched to the trial preparation, WC-961, and were instructed to take one tablet in the morning and one in the evening. After a similar period of observation, the efficacy of this preparation was also scored and these results were compared with those obtained with the control preparation.

The following criteria were used in scoring therapeutic response: Excellent: Complete or almost complete relief of symptoms within thirty minutes after taking medication, with relief lasting four or more hours; Good: If relief was between 50 to 75 per cent and lasted two or more hours; Fair: 25 to 50 per cent relief of symptoms; Ineffective: If relief of symptoms was less than 25 per cent.

TABLE 1

EFFECTIVENESS OF THE "CONTROL PREPARATION" AND WC-961 IN PATIENTS WITH BRONCHIAL ASTHMA*

	Medication	
Clinical Response	*Control*	*WC-961*
Excellent	14 (28%)	36 (72%)
Good	28 (56%)	6 (12%)
Fair	8 (16%)	7 (14%)
Ineffective	0	1 (2%)
Total	50 (100%)	50 (100%)

*See text.

We expected that this system of scoring would tend to bias the results in favor of the control preparation for the reason that a larger amount of the bronchodilator compound becomes available within the first 4 hours.

Results.—Inspection of the data (Table 1) indicates that both the control preparation and WC-961 were effective in reducing some or all of the manifestations of bronchial asthma in virtually all patients. When compared with the control drug, however, it was noted that more than three times as many patients on WC-961 scored an excellent response, the difference between the two being statistically significant. If we compare the efficacy of the two preparations by degree of severity (Table 2), there is a suggestion that patients with severe asthma fared better when treated with WC-961 than when treated with the control medication. From this, it may be surmised that the new formulation of WC-961 provides, because of its immediate and prolonged activity, an unusual therapeutic effect. The significance of this observation remains to be explored.

With the control preparation, two patients complained of drowsiness and two of nervousness. With WC-961, drowsiness was reported by two patients and three others noted nervousness. None of these effects was important enough to warrent discontinuance of either medication.

Comment

In the absence of "suitable controls," a drug assessment presents a considerable problem because of the tendency on the part of patients to give a new drug enthusiastic support. There are,

TABLE 2

EFFECTIVENESS OF THE "CONTROL PREPARATION" AND WC-961 BY SEVERITY OF ASTHMA FOR FIFTY PATIENTS*

		CONTROL				WC-961			
Severity of Asthma	*No. of Cases*	*Excellent*	*Good*	*Fair*	*Ineffective*	*Excellent*	*Good*	*Fair*	*Ineffective*
Severe	22	5	11	6	0	17	2	2	1
Moderate	17	5	12	0	0	12	4	1	0
Mild	11	4	5	2	0	7	0	4	0
Total	50	14	28	8	0	36	6	7	1

***See text.**

moreover, the usual variations to be considered among patients with bronchial asthma and the difficulty in evaluating subjective symptoms. These limitations notwithstanding, our experience with WC-961 indicated that this newly formulated preparation provided very satisfactory control of symptoms in the large majority of patients with bronchial asthma.

A recent report[11] suggests that a blood theophylline value of 150 to 200 mcg./100 ml. may be adequate to induce bronchodilatation in asthma. As shown in Figure 1, a single tablet of WC-961 produces blood theophylline concentrations well

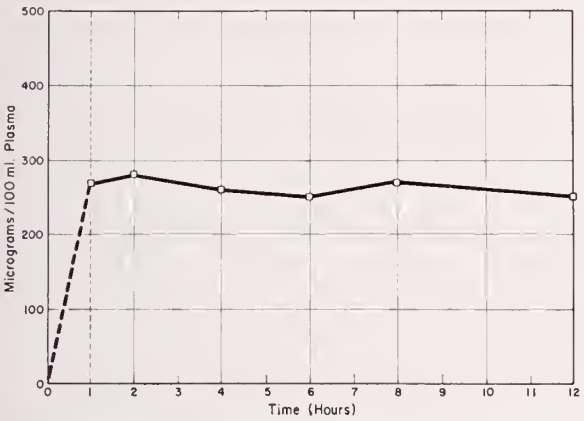

Figure 1: Mean theophylline blood levels in 10 patients following the administration of a single WC-961 tablet.

within this range shortly after administration and maintains them for twelve hours,[12] which may help to explain its effectiveness.

Summary

1. The vast majority of patients with asthma are effectively treated with the relatively simple adrenergic drugs or the methylated xanthines, or both. The water-alcohol theophylline preparations with and without glyceryl guaiacolate and the newly formulated compound described herein, WC-961, have been shown to be well tolerated and effective oral bronchodilator preparations. These theophylline preparations have done much to advance the day to day therapy of bronchial asthma.

2. When full trial with adrenergic and xanthine preparations fails to provide the desired results and asthma becomes intractable, anti-inflammatory steroids are indicated. A serious attempt must be made to aim for short-term therapy. When administered in repeated courses or as maintenance therapy, these hormones may give rise to undesirable and often serious side effects which circumscribe their usefulness. These hazards have not been lessened by the newer, chemically modified anti-inflammatory steroids.

Acknowledgment

The author wishes to express his gratitude to Mr. William E. Murphy for his editorial advice.

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Physiological Considerations in the Management Of Bronchial Asthma and Pulmonary Emphysema*†

Gustav J. Beck, M. D.

THE purpose of this paper is to present a physiological approach to the management of bronchial asthma and pulmonary emphysema. Pioneer work by physiologists and physiologically oriented anatomists[1, 2, 3, 4] provided much information toward a better understanding of the mechanics and biochemistry of respiration in bronchopulmonary disease. The knowledge gained from these investigations was then applied to methods of treatment designed to correct the basic disturbances. Pulmonary function testing, originally confined to highly specialized laboratories, has been simplified to the extent that such procedures can be performed with a high degree of accuracy in every community hospital. A good estimation of the patient's diagnosis, ventilatory reserve, response to treatment, and progress can be obtained by simple lung function tests in every clinician's office. Better planning of pharmacologically and physiologically directed therapy results from an evaluation of the patient's pulmonary reserve. A brief review of methods of evaluating respiratory reserve will introduce this report.

Pulmonary Function Te ting

This section will be limited to practical measures which determine the ventilatory function of the lung. In obstructive bronchopulmonary disease, the important parameters which can be tested rapidly and with a fair degree of accuracy by the practicing physician are the vital capacity, the expiratory volume flow rate and the swift expiration. From these determined values an approximate value for the maximal breathing capacity can be derived.

A useful method consists of a bellows-shaped device into which the patient exhales completely, first slowly and then rapidly, following the deepest possible inspiration. By means of a flow-sensitive gauge and a small electric motor, initiation of expiration triggers into motion a recording platform containing graph paper (Vitalor, McKesson-Robbins Co., Toledo, Ohio). A small stylus records the rate of ascent of the bellows while it is being inflated by the patient. In this manner the mid-expiratory flow rate, determined during a maximal swift expiration, as well as the flow rate during each second of expiration, can be estimated. The vital capacity during a maximal slow and swift expiration can be obtained on the same graph, while the platform remains stationary. Comparison of the latter two volumes with each other,[5] and the vital capacity and expiratory flow rates with those predicted for normal subjects of the same age will furnish a fair estimation of the degree of expiratory obstruction.[6] These tests, used before and after the administration of a bronchodilator aerosol, determine the response of the bronchial obstruction to these pharmacological agents and, therefore, are of value in planning an effective therapeutic regimen. The complete test requires eight to ten minutes including calculation of the results and has the advantage of providing a permanent graphic record.

Important information may be obtained from the determination of the minute volume of ventilation, respiratory rate and tidal air, while the patient inhales air on one hand and 100 per cent oxygen on the other.[4, 7] A Benedict-Roth type of spirometer is the most accurate equipment for this purpose. A breathing device with an inspiratory and expiratory valve, the latter leading to a gasometer and, for breathing 100 per cent oxygen, a demand regulator on an oxygen tank is simpler. A stop watch is used to time the procedure, while the number of respirations are counted. In normal subjects the minute volume breathing 100 per cent oxygen equals or exceeds that obtained while breathing room air. In patients with chronic hypertrophic pulmonary emphysema the value of the minute volume breathing 100 per cent oxygen usually is lower than that for breathing air.

The difference between these two values is an index of the degree of relief of dyspnea experienced by the patient when the oxygen saturation of the arterial blood is raised. This device car

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*Presented before the Fifth Annual Meeting of the West Virginia State Society of Allergy, held during the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25, 1962.

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Submitted to the Publication Committee, May 16, 1962.

be used also to determine the degree of relief of dyspnea obtained when a patient with pulmonary emphysema initiates diaphragmatic respiration by assuming the head-down or leaning forward position or by lying prone with a 15 pound shot bag on the lower abdomen, as compared with the sitting position.[8,9,10] Each minute volume test must be conducted for six to seven minutes for purposes of reliability. The results obtained by this method are of prognostic significance and serve as a good estimation of the effectiveness of a therapeutic regimen followed over a long period of time.

Detailed accounts of the methods used to determine the residual volume, efficiency of intrapulmonary mixing, gas diffusion, alveolar perfusion, arterial blood gas and pH determinations, airway resistance and compliance are beyond the scope of this paper. The importance of these determinations in the accurate evaluation and responsible management of pulmonary emphysema cases where complications develop cannot be overemphasized. Most of these tests, with an accurate interpretation by the clinical pathologist of a hospital laboratory, should be made available to the physician charged with the patient's care.

Physiological Basis of the Therapeutic Regimen

When faced with the treatment of the patient with obstructive bronchopulmonary disease, the following disturbances of physiological mechanisms should be borne in mind.

1. Bronchial spasm and inflammation.
2. Bronchopulmonary infection and impaired bronchial drainage.
3. Improper distribution and mixing of the inspired air in the alveoli.
4. Hypoxia, carbon dioxide retention and acid base imbalance.
5. Secondary effects on the pulmonary circulation.
6. Secondary effects on the red blood cell mass.

In normal subjects the bronchial tree widens and elongates during inspiration, and narrows and shortens during expiration. In bronchial asthma and pulmonary emphysema the inflamed bronchial mucosa, obstructed by mucus or purulent plugs, exaggerates the expiratory narrowing, resulting in a more turbulent air stream which is clinically detectable as prolonged and diminished expiratory breath sounds ending in a wheeze. To compensate for this excessive expiratory obstruction, the patient assumes a more inspiratory midposition by leaning forward, thereby hyperextending the dorsal spine and increasing the flare of the ribs. By pursing the lips during expiration, a back pressure is created throughout the bronchioles, increasing their diameter and providing improved air movement during that phase of the respiratory cycle.

The premature expiratory bronchiolar collapse in emphysema leads to "trapping" of inspired air in the alveoli. This results in overdistention and rupture of the air sacs, a decreased alveolar surface available for gas exchange and reduction in size of the pulmonary arteriolar bed. Bullae are produced by alveolar overdistention and rupture of the alveolar walls as a result of a ball valve mechanism in the bronchioles during end-expiration. Overdistention of the chest cage, clinically recognizable as the "barrel chest," and depression of the leaves of the diaphragm into a more inspiratory position result from the alveolar overinflation. The capacity of the lung to retract toward the hilum during expiration is diminished by the loss of elastic fibers in its supporting structure. The expiratory elevation of the diaphragm in normal subjects results from the retraction of the lung toward the hilum. Interference with this mechanism results in fixation of the diaphragmatic leaves in an inspiratory position and diminution of their piston action which normally contributes two-thirds of the total alveolar ventilation. The loss of this efficient contributor to the respiratory reserve provides a further impediment to the already compromised pulmonary gas exchange.

As infection and inflammation of the bronchial tree continue to obstruct a larger number of bronchioles, the respiratory reserve diminishes gradually. Cough becomes ineffective because of the diminished volume of air exhaled through the markedly narrowed bronchioles. Accumulation of secretions in the bronchioles, resulting from impaired bronchial drainage, leads to further infection of the mucosa and more damage to the lung.

Uncompensated Respiratory Acidosis

As interference with the ventilatory mechanism and the distribution of inspired air in the alveoli increases, hypoxia and carbon dioxide retention result. For some time the acid-base equilibrium can be maintained by compensatory urinary, and sometimes gastric, chloride-ion excretion. When these two mechanisms fail, uncompensated respiratory acidosis, with lowering of the blood pH, occurs. The most frequent causes of uncompensated respiratory acidosis in obstructive bronchopulmonary disease are sedation (opiates, barbiturates, tranquilizers), large amounts of oxygen by inhalation, and severe bronchopulmonary in-

fection. Clinical signs of the condition are hypoventilation, drowsiness, irritability (going on to confusion), irrationality and coma, followed by death if no treatment is given.

Changes in structure of the lungs of emphysematous patients result in a marked decrease in size of the pulmonary capillary bed, without much change in the total right cardiac stroke volume. This may be accompanied by increased viscosity of the blood due to polycythemia. Hypertension of the pulmonary circulation results, followed by a compensatory right heart muscle hypertrophy and eventually right heart decompensation.

An effective therapeutic regimen must be directed toward the correction of all aberrations of physiological processes occurring in chronic obstructive bronchopulmonary disease.

Therapeutic Management of Chronic Bronchial Asthma And Pulmonary Emphysema

General Management.—Bronchial asthma patients who furnish a history suggestive of extrinsic etiological factors benefit from a complete investigation of their allergic tendencies and a consistent program of desensitization and avoidance of offending allergens. Chronic severe dyspnea frequently is associated with anorexia and may result in dehydration and malnutrition. An increase in food and fluid intake and supplementary vitamins, administered parenterally if necessary, will correct these deficiencies. The attitude toward the patient should be one of continuous encouragement. A good understanding of his disease and of the reasons for the measures adopted contribute much to the patient's conscientious execution of the program outlined to him by his physician.

Therapy of Bronchial Spasm and Infection.—The most effective oral bronchodilators are derivatives of ephedrine or aminophylline. The Dainite Day Tablet (Irwin, Neisler and Co.), on arising and at 3 p. m. and the Night Tablet at bedtime provide excellent relief of bronchospasm with little gastrointestinal irritation. An elixir of theophylline (Elixophylline-Sherman Laboratories), 3-5 tablespoons at breakfast and bedtime relieves wheezing promptly.

Aerosol therapy is provived effectively by a De Vilbiss #40 or #42 or a vaponefrin hand bulb nebulizer, using a mixture of isoproterenol and phenylephrin (Nebu-prel, Thomas J. Mahon, Inc.), or undiluted 2.25 per cent racemic epinephrine (Vaponefrin-Vaponefrin Co.), or 0.5 per cent isoproterenol (Isuprel-Winthrop Laboratories) or a mixture of racemic epinephrine and atropine (Dylefrin-Irwin, Neisler and Co.). More prolonged and effective diminution of wheezing is obtained by means of a "mouth rebreathing aerosol apparatus" with propulsion by a motor or pump. A dilute mixture of 0.3 cc. of 2.25 per cent racemic epinephrin or 0.5 per cent isoproterenol, with 0.5 cc. of 1 per cent phenylephrine and 2 cc. isotonic saline is inhaled as an aerosol with this device three to four times daily. Intermittent positive pressure breathing devices may be used in the same manner for this purpose but in our experience have offered no additional advantage for the relief of bronchospasm.

When aminophylline is administered intravenously, a dilution of 0.5 Gm. in 300 cc. of 5 per cent dextrose in water has the advantage of a swift rise of the blood level and prompt effective response. This drug may also be used rectally in the same dose, diluted in 30 cc. of tap water. A derivative of aminophylline diluted and ready for rectal use in a plastic bottle is also available (Clysmathane—C. B. Fleet Co.).

If bronchodilators and measures described in the foregoing paragraphs fail to relieve bronchospasm the use of steroids is indicated. A high initial dose of the corticosteroids achieves a rapid response, and may be followed by gradual diminution of the dose. Prednisone, one of the most effective steroids with least side effects, is given initially in doses of 30 to 80 mg. daily, depending on the severity of the bronchospasm. Gradual reduction of the dose should be followed by an attempt at discontinuation of the drug. There appears to be no clinical advantage to the concomitant use of adrenocorticotrophic hormone, and the problem of increased sodium retention and occasional allergic reaction may become a hindrance to effective therapy. When repeated attempts to discontinue steroids fail in the patient with severe bronchospasm, maintenance therapy on a dose of 5 to 20 mg. daily might have to be instituted.

An oral antacid preparation must be administered one to two hours after meals, whenever steroids are used, to prevent complications due to gastric irritation. In the presence of a history, clinical or x-ray evidence of arrested pulmonary tuberculosis, the concomitant use of isoniazid or streptomycin is recommended.

Management of Bronchial Infection and Promotion of Bronchial Drainage.—The mechanisms responsible for recurrence of bronchial infection in bronchial asthma and pulmonary emphysema are intimately associated with structural and physiological abnormalities of the bronchi which interfere with bronchial drainage, as previously outlined. Therefore, measures designed to im-

prove bronchial drainage have a beneficial effect upon the prevention of infection. Relief of bronchospasm by the aforementioned methods promotes the elimination of secretions. A heated aerosol is administered for 20 minutes twice or three times daily by means of a thermostatically controlled, pump propelled, aerosol generator (Superheated Aerosol-Inhalational Equipment Co., 1686 Second Avenue, New York, N. Y.). Three to four ounces of isotonic saline are deposited on the tracheobronchial tree, which facilitate expectoration of the thick, tenacious secretions prevalent in these diseases.[11] Expectorants such as iodides, ipecac and ammonium chloride appear to improve bronchial drainage.

Reduced expiratory flow rates and trapping interfere with the mouthward propulsion of mucus. To overcome this mechanical defect, pursed lip breathing should be practiced by the patient during each expiration immediately following aerosol inhalations. Simultaneously the lower lateral thorax should be compressed and the diaphragm elevated by intermittent manual pressure. This procedure decreases the degree of trapping and augments the expiratory flow rate by increasing the bronchiolar diameter, and is followed by the free expectoration of mucus.

The nature of the phlegm is ascertained by examining a stained smear microscopically for leukocytes and bacteria. The presence of eosinophilic leukocytes confirms an allergic component in the patient's illness. Neutrophil leukocytes and bacteria are an indication of infection; if these are present the sputum should be subjected to culture and sensitivity studies. The choice of antibiotics is made on the basis of these results. An initial dose of 1½ times the recommended maintenance dose of the selected antibiotic administered for two days results in rapid control of the infection. The recommended maintenance dose of the antibiotic is continued for a period of five to seven days. In some cases of chronic bronchopulmonary disease, continuous administration of a suppressive dose of a sulfonamide or a broad spectrum antibiotic appears to be effective in diminishing the incidence and reducing the severity of infection.

Reduction of Dyspnea by Improving Alveolar Ventilation.—Because of physiological considerations previously mentioned, a program of training designed to encourage diaphragmatic motion during quiet respiration should be instituted for the patient with pulmonary emphysema. The initial step in this program consists of placing the patient in the head-down position whereby the weight of the viscera pushes the diaphragm into the chest during expiration and permits a subsequent active contraction of its leaves during inspiration. This maneuver results in decreased dyspnea and a diminished minute volume of ventilation, without appreciable changes in arterial oxygen saturation, carbon dioxide content or pH.[8]

Increased diaphragmatic motion can be achieved by increasing the intra-abdominal pressure with a 15 to 20 pound shot bag resting on the lower abdomen while the subject lies flat. The patient executes these procedures twice or three times daily for one-half hour, following aerosol therapy.

Leaning forward while sitting or standing, with a Gordon-Barach belt (Spencer Co., New Haven, Connecticut) supporting the lower abdomen, increases diaphragmatic mobility by increasing abdominal pressure against the diaphragm.[10] Ambulatory patients frequently observe a decrease in exertional dyspnea when wearing this type of abdominal support.

Correction of Hypoxia, Carbon Dioxide Retention and Acid-Base Balance.—The asthmatic patient during an acute attack of bronchospasm is frequently severely hypoxic. When pulmonary emphysema is not predominant, oxygen may be administered in high doses to correct the hypoxia, preferably with an expiratory positive pressure mask. In the presence of pulmonary emphysema, hypoxia must be treated by a carefully supervised program to avoid the acute hypoventilation syndrome and uncompensated respiratory acidosis. Using a double nasal canula, oxygen is administered for 24 hours at 1 lit./min.; the flow is increased daily by 1 lit./min. until 4 to 5 lit./min. is reached on the fourth or fifth day. When the patient has improved, the flows are reduced following the same schedule in reverse.[10, 12] At the slightest indication of drowsiness, indicative of uncompensated respiratory acidosis, an arterial blood pH should be obtained. If the diagnosis of uncompensated respiratory acidosis is confirmed, the inspired oxygen concentration should be reduced and respiratory stimulants, e. g., caffeine sodium benzoate 0.5 to 1 Gm. or amphetamine 5 to 10 mg. must be given parenterally. Intermittent positive pressure breathing devices are useful in inducing hyperventilation to reduce the arterial pCO_2. Emivan[13] (U. S. Vitamin Co.) has been described as an effective respiratory center stimulant.

Uncompensated respiratory acidosis resulting from an acute infection or oversedation of a patient with severe pulmonary emphysema is managed in a similar manner. Initiation of a course of steroids, or markedly augmenting the dose in patients maintained on that drug, materially improves the rate of recovery.

Recent studies[12, 14] have shown that the exercise tolerance of patients with severe pulmonary emphysema can be greatly increased by a graded walking exercise program, using oxygen by inhalation. A 50 foot length of rubber tubing connected to the gauge of a standard sized tank or preferably a portable refillable tank with a two-stage gauge and a nasal canula are used for this purpose (Oxyhale 50 or 100, Controlled Pressure Co., Erie, Pennsylvania). Using a flow of 6 to 8 lit./min. through the nasal canula, the patient walks 100 steps twice daily, followed by 50 steps without oxygen. The number of steps is increased daily by 100 steps with oxygen by canula at 6 to 8 lit./min. and by 50 steps breathing room air, until a walking program of 1,000 steps breathing oxygen and 500 steps breathing air is achieved. Subsequently, if possible the number of steps breathing oxygen may be reduced while the number of steps breathing air may be increased. The successful completion of this program frequently not only raises the patient's exercise tolerance greatly, but also restores confidence in his achievement and improves his general attitude and outlook.

Management of Cor Pulmonale and Pulmonary Hypertension.—The earliest clinical signs of hypertension of the pulmonary circulation are accentuation of the second pulmonic sound and change in the electrical axis toward the right. An x-ray of the chest may indicate an increase in the hilar vascular markings due to an increase in the size of the pulmonary arteries in the presence of pulmonary emphysema and fibrosis. When the oxygen concentration in the inspired air is increased, the pressure in the pulmonary artery falls as hypoxia is corrected. With maintained pulmonary hypertension enlargement of the right ventricle occasionally appears on the chest x-ray. More commonly the heart shadow gives the appearance of becoming narrower and longer as the leaves of the diaphragm become depressed.

The first clinical sign of impending decompensation of the right ventricle is persistent tachycardia at rest. Other etiological factors of tachycardia, with special reference to the sympathomimetic drugs administered by aerosol or orally, must be eliminated before the diagnosis of early right ventricular failure can be made on this basis. The inhalation of oxygen may reduce tachycardia that is due to right ventricular failure; in the presence of pulmonary emphysema, however, the precautions noted above for oxygen therapy must be followed. Digitalis or synthetic glycosides reduce the tachycardia at that stage. A rise in venous pressure, ankle edema and hepatic enlargement with tenderness are the indicators of progressive right ventricular decompensation. Digitalization and diuretics (diamox, chlorthiazide derivatives, mercurials or spirolactone) in conjunction with the inhalation of small graded concentrations of oxygen comprise the treatment of decompensated cor pulmonale.

The effects of the diuretic on the electrolyte balance must be observed. Clinical signs and laboratory evidence of imbalance are easily corrected by the administration of supplementary electrolytes. Diuresis also results in loss of water-soluble vitamins which must be replaced to avoid acute deficiency syndromes. When right ventricular failure occurs acutely, correction of the underlying etiological factor, such as bronchopulmonary infection or severe bronchial obstruction complicating the chronic emphysematous process, may induce spontaneous diuresis and compensation.[15]

Correction of Polycythemia.—The plethoric appearance and an elevated hematocrit in some cases of pulmonary emphysema constitute the clinical picture of secondary polycythemia. An elevated hematocrit without plethora may be indicative of hemoconcentration due to dehydration. Rapid correction of this phenomenon is achieved by greatly increasing the patient's fluid intake. Once the diagnosis of secondary polycythemia is established, the treatment of choice is repeated phlebotomy of 300 to 400 cc. until the hematocrit falls to 45 mm. Since an increase in the red blood cell mass may intensify pulmonary vascular hypertension, phlebotomies may result in diuresis when right ventricular decompensation prevails.

Additional Measures Employed in the Management of Bronchial Asthma and Pulmonary Emphysema.—When the severity of bronchial spasm, edema or obstruction by phlegm remains unrelieved by the measures described, inhalation of a 35 per cent oxygen, 65 per cent helium mixture at a 12 to 15 lit./min. flow from an expiratory positive pressure mask decreases the work of breathing and dyspnea.[16] In circumstances of extremely severe bronchial obstruction, tracheostomy may be lifesaving. The indications for tracheostomy in pulmonary emphysema are severe airway obstruction, hypoxia or uncompensated respiratory acidosis with hypoventilation unrelieved by the other measures indicated above. Ventilation may then be assisted by a cuffed tube inserted in the trachea through the stoma, by means of an intermittent positive pressure device, and oxygen.

Isolated large emphysematous bullae compressing relatively healthy lung tissue may be sur-

gically removed, with dramatic relief of dyspnea and increase in respiratory reserve. The effectiveness of resection or plication methods to remove peripheral bullae in generalized hypertrophic pulmonary emphysema cannot be judged until complete evaluation of these surgical procedures from the pulmonary function and follow-up point of view has been accomplished.

The enzymes and detergents by aerosol for the treatment of bronchial asthma have shown no advantage over bronchodilators with isotonic saline, in our experience. The use of antibiotics by aerosol in bronchial asthma has been abandoned because of the high incidence of bronchial irritation. Their use in pulmonary emphysema or chronic severe infection of the bronchial tree is now restricted to polymixin or neomycin, in cases in which the offending micro-organisms are selectively sensitive to these drugs. Bronchodilators are used in conjunction with these antibiotics administered as an aerosol.

Summary

The effectiveness of therapy directed at relieving dyspnea of patients with bronchial asthma and pulmonary emphysema is enhanced by a recognition of the abnormalities of physiological mechanisms occurring in these diseases. Pulmonary function testing by simple methods can furnish excellent information about the diagnosis, course and prognosis of the disease process and about the response to therapy.

The following measures designed to correct disturbances of physiological mechanisms are suggested: (1) bronchodilators by aerosol and orally with steroids to relieve bronchospasm and bronchial inflammation, (2) expectorants, heated saline aerosols and lower thoracic compression during expiratory pursed lip breathing to promote bronchial drainage; antibiotics to control infection of the lungs and bronchial tree, (3) a program of breathing exercises to improve ventilation and reduce dyspnea by increasing the ventilatory contribution of the diaphragm, (4) correction of hypoxia during rest and exercise, achieved by a carefully supervised program of inhalation of increased concentration of oxygen; prevention and treatment of uncompensated respiratory acidosis, (5) compensation of right ventricular failure by digitalis preparations, diuretics and attention to the underlying bronchopulmonary problem and (6) repeated phlebotomy to relieve the symptoms and prevent the complications of polycythemia.

The indications for tracheostomy, surgical resection of emphysematous bullae, antibiotic enzyme and detergent aerosol therapy are discussed.

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. . . there is nothing quite so complicated as simplicity.

CHARLES POORE.

Chronic Lung Disease: Group and Clinic Therapy*†

William A. Hopkins, M. D.

Chronic bronchopulmonary obstructive disease is becoming the No. 1 pulmonary problem in this country. It is estimated that 15,000,000 Americans are suffering some degree of incapacity from this debilitating and tragic disorder. Early manifestations may be a mild recurrent cough, or recurrent bronchitis. This gradually changes over to progressive evidence of dyspnea. Soon typical signs of obstructive breathing are present. Since the problem is universal today, it is not surprising that many areas are devoting full time in an attempt to alleviate distress, as it applies to the disease.

It is our purpose to discuss a rational therapeutic approach in handling large numbers of these patients. We do not say that the methods we are using and presenting here today are the only means of helping these patients. We do say that we believe our plan is a sensible therapeutic approach in their management.

We know that opinion differs as to the most satisfactory method of handling these patients, just as we know that rehabilitation and relief of the obstructive phenomena of the disease constitute the main purpose of all those treating emphysema. We believe that group therapy of patients with chronic pulmonary obstructive disease is a most gratifying method. The psychological effect on these patients from seeing other members of the clinic participate in the therapy program and achieve improvement is far greater than that of the individual patient attempting forms of therapy on his own. The exact part that the psychological effect of group therapy plays in the improvement we are observing has not been completely evaluated at this time.

In discussing any form of therapy for persons with chronic obstructive pulmonary disease, one must go into it with optimism. I strongly condemn the general attitude of the profession manifested in stating to an individual, "Oh, you have pulmonary emphysema. There really is nothing that can be done for it." We hear this over and over again and I feel that it is indeed a blight on the character of our profession for anyone ever to say it. It is true that we are not removing the lungs of these patients and putting in new ones as yet, but I doubt that there is any patient who cannot obtain benefit from an intelligent and guided therapeutic regimen. Thinking in terms of group therapy there is no problem as regards colleagues because I do not know of any disease in which the "dumping syndrome" is so prevalent. Most physicians, who are not intensely interested in chronic bronchopulmonary obstructive disease, find the results of inadequate therapy so discouraging that they are perfectly willing to see their patients go any place where they can obtain relief.

In addition to these factors, group therapy has a distinct advantage in the training of technical assistants for aiding other groups of patients in various areas. The establishment of clinics in communities tends to encourage the physicians in those communities to become more familiar with the techniques now available for helping these patients. It was with this thought in mind that we began our attempt to establish clinics in our own state for the treatment of these unhappy, yet grateful, patients. At present four such clinics are under organization in our state. It is felt that they can be established without a great deal of cost. They may be maintained by various health agencies. It is felt that such a project would be ideal for the tuberculosis associations to undertake. Most associations have adequate facilities and the know-how to accomplish such a purpose. With the aid of their medical advisory committees they could establish these clinics throughout any given state. It is our hope, in Georgia, that with the aid of the Department of Health, the Tuberculosis Association, and the medical schools, we can establish a statewide system of pulmonary clinics for the rehabilitation of patients with chronic lung disease. These clinics also would aid

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***Presented before the Fifth Annual Meeting of the West Virginia State Society of Allergy, held during the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25, 1962.**

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Submitted to the Publication Committee, May 16, 1962.

in the over-all care and evaluation of patients with all types of lung disease.

The term, "chronic lung disease," has many facets. Generally, we think of it in terms of the advanced emphysema patients with pulmonary fibrosis and obstructive breathing. In this group also are those patients with asthma, bronchiectasis, pneumonoconiosis, the chronic inflammatory bronchopulmonary disorders, and fibrocystic disease of children. It is not within the scope of this paper to discuss the etiology and differential diagnosis of this group of patients. Suffice it to say that the one common characteristic of the group is the development of chronic obstructive breathing.

Simple and Advanced PFT's

In evaluating the results of therapy, numerous pulmonary function tests are needed to give an accurate scientific appraisal. Advanced tests of pulmonary function can be done only in well equipped laboratories with well trained personnel. There are, however, some simple tests of pulmonary function that can be done in most any clinic. The attempt to blow out a match with the mouth open, or determining the dyspnea of a patient in relation to known exercise will give a fairly accurate appraisal of his incapacity. An excellent means of determining the degree of emptying the lungs is by fluoroscopy. All chest clinics should have a fluoroscope available, with trained personnel able to evaluate pulmonary emphysema. We have found that the mean expiratory flow rate is a simple screening test that may give a lot of information to the patient and the physician as to the progress of therapy. We have encouraged the use of a simple spirometer because it is relatively inexpensive, and the patients and technical assistants can learn to handle it capably. It is true that there are many limitations in this type of pulmonary function test, yet it serves the purpose of a general chest clinic.

We have available several laboratories fully equipped for advanced tests. We hope to integrate these with the clinics so that in certain cases the patient may obtain advanced studies. With the small spirometer, both the mean expiratory flow rate and the vital capacity can be obtained. A small chart may be kept and the patient can note his improvement on return visits. This, together with the clinical information obtained from the patient, can give the physician in charge of the clinic a fairly accurate idea as to the effectiveness of the treatment in the individual case.

Our therapeutic approach is divided into four general categories: (1) medical, (2) exercises, (3) oxygen breathing and (4) mechanical ventilators.

Medical

The control of infection is of utmost importance in handling any problem in relation to pulmonary disease. Some reports indicate that less than 5 per cent of respiratory infections are bacterial in origin,[1] yet secondary bacterial invasion almost always is present. If there is purulent exudate in the sputum, antibiotic therapy is a must. Examination of the sputum by gram stain is most helpful in determining the presence both of leukocytes and bacteria. This should be followed by adequate culture studies of the sputum, with sensitivity studies of the bacterial flora. If there is absence of polymorphonuclear leukocytes on the smear, one may desist the use of antibiotics. One of the cardinal principles in the treatment of chronic pulmonary disease with antibiotics is prolonged use of the drug. Sometimes four to six weeks of oral administration, either of penicillin or a broad spectrum antibiotic, is essential in clearing chronic bronchial infection in the presence of obstructive lung disease. I would like to point out, however, that the use of antibiotics alone without proper drainage procedures in this situation is generally of no value. It has been found that Staphylococcus is a very common organism in children with fibrocystic disease[1] and therefore the use of Staphcillin or Prostaphlin on a long-term basis has foundation. If the Staphylococcus is sensitive to other drugs, they may be used instead.

Bronchodilator drugs used orally, parenterally or in aerosol preparations are extremely helpful in combating many of the problems related to obstructive breathing. At present, our major sources of bronchodilators are the aerosols; these will be discussed later in this paper. Aminophylline, however, may be given orally, if tolerated; intravenous Aminophylline may be of help in acute bronchospastic disease. Rectally, 0.5 Gm. of Aminophylline in 30 cc. of water once or twice a day is far more effective than suppositories. We have found that Choledyl is well tolerated by our patients, is easier to handle and in our hands has given us better results. We have used 200 mg. of Choledyl with meals and at bedtime. Our clinical impression is that our patients have received more benefit from this drug than from any other xanthine used. It has been proven safe and is well tolerated, especially by the elderly patient. It is our observation that the use of this drug has reduced the severity and number of attacks of acute bronchospasm in our group of patients. We

have not found ephedrine orally to be very effective except in those patients with mild bronchospasm.

The use of steroids has been limited to patients not relieved by other methods. We feel that there is some danger in maintaining older patients with bronchospastic disease on steroids for any length of time, except for the relief of acute problems. It is felt that if used, associated antacids should be maintained continuously. We have used Prednisone 30 to 50 mg. daily in divided doses, with gradual reduction in approximately a week to a maintenance dose of 10 to 15 mg. daily. Because it is difficult to determine the possible activity of tuberculosis in many patients with advanced pulmonary fibrotic disease we have preferred not to use the steroids in this particular group of patients.

Mucolytic agents have been used in only a very small group of patients. We have not been impressed with the effectiveness of these compounds. Recently we have been using an aerosol preparation of Dornavac[2] in those patients having extremely tenacious secretions, with evidence of considerable bronchial infection.

Generally speaking, in rather advanced emphysema the combination of all types of treatment is most important to overcome the problem of obstructive breathing.

Respiratory Acidosis.—The correct medical treatment of respiratory acidosis should be understood thoroughly by all persons engaged in active treatment of patients with advanced pulmonary obstructive phenomona. Respiratory acidosis is generally indicated by fall of the pH below 7.38 and clinically by mental confusion and even loss of consciousness. It may be precipitated by the injudicious use of oxygen and has been well described in the literature.[3]

The treatment of this disturbing syndrome is not necessarily the removal of oxygen. We feel that a hypoxic, cyanotic patient requires continued oxygen therapy. The amount of oxygen, however, may be decreased and, in addition, the patient may be stimulated to better ventilation by several methods. Chemical means of stimulating the respiratory centers are available. Caffein sodium benzoate intramuscularly, 0.5 to 1.0 Gm. at 3 to 6 hour intervals, is helpful. Benzedrine or Dexedrine orally, 10 to 20 mg. daily, is most helpful. Emivan, used intravenously or intramuscularly, in doses of 40 mg. at bedtime, often may be sufficient to return the patient to his former status. Intermittent positive pressure breathing for mechanical hyperventilation is imperative. If hypoventilation continues and is severe, tracheostomy with cuffed tube and hyperventilation with one of the mechanical ventilators are recommended. Continued treatment of the patient's basic problems is necessary in order to maintain the patient in any adequate ventilatory state.

Patients showing evidence of advanced cor pulmonale usually are put on a salt restricted diet. Digitalis is helpful, although not as effective here as in other types of heart failure. Diuretics are used both intramuscularly and orally, but all of these measures are secondary to adequate ventilation of the patient and adequate means of clearing the airway of obstruction.

Exercises

Much of the difficulty in chronic obstructive pulmonary disease results from mechanical disturbance of respiratory function which can be only partially corrected by drug therapy. Many workers[4] as early as 1936 emphasized the importance of a physical approach to the treatment of patients with chronic dyspnea. Miller[5] recently has pointed out the importance of breathing training in patients with emphysema.

The scope of this paper does not permit details of training for better breathing. These are well described elsewhere.[5, 6, 7, 8] The methods may be divided into abdominal diaphragmatic breathing, pursed lip breathing, and the use of accessory means of abdominal diaphragmatic support.

In quiet abdominal diaphragmatic breathing, the patient is placed with the head down in a 20 to 30 degree position. An 8 to 10 pound sandbag is placed on the lower midabdomen. The patient is then instructed to blow out with his lungs and breathe in with his abdomen. An intense training program of abdominal inspiration and thoracic expiration is most important. He is taught to elevate the sandbag as he breathes in, and to contract his abdomen as he breathes out. This also aids in postural drainage and removal of secretions.

Pursed lip breathing is an aid in emptying the lungs. The added use of manual compression of the lower chest and upper abdomen, as described by Barach,[6] is efficacious in helping the patient empty his lungs. It might be assumed that the addition of pursed lip breathing increases the obstruction in an already chronic obstructive lung. There is a major difference, however, between the intrapleural space pressure and the lower intrabronchial space pressure during the expiratory phase. This causes early collapse of the smaller nonsupported bronchi. Pursing the lips more nearly equalizes the pressure and keeps the lower

level bronchi from collapsing prematurely and, therefore, enables better emptying of the lungs.

The use of an abdominal support such as the Gordon-Barach emphysema belt[8] is helpful in some patients. Not all patients are aided by this procedure but a simple test may determine potential benefit from the belt. If, under fluoroscopic guidance, one sees the elevation of the diaphragm increase with abdominal compression and at the same time notes a decrease in dyspnea, the belt usually will be efficacious. Accessory muscle correction may be of considerable benefit to patients with obstructive emphysema.[5] In younger patients corrective postural exercises are most helpful. The so-called military bearing, however, is improper in the case of the asthmatic or emphysematous patient, because it places the chest in an inspiratory position and limits expiratory efforts. General physical activity plays a leading role in the over-all program to maintain muscle efficiency. It must be controlled within the limits of the patient's ability. The addition of oxygen breathing may be of considerable aid in the breathing training and exercise program.

All of this can be carried out much better under clinic direction, with patients demonstrating to other patients. The competitive incentive is most helpful in improving pulmonary function. It is indeed most interesting to watch patients, on a competitive basis, trying to improve their diaphragmatic breathing, or instructing one another in the proper use of the abdominal belt. Oxygen breathing is not only an aid to the exercise training program and breathing rehabilitation of patients with obstructive pulmonary disease, but actually is of therapeutic value to patients with advanced pulmonary emphysema. Although we have had only limited experience with this form of therapy, we feel that it is ideally suited to a clinical approach to treatment in large groups of patients. In one of our clinics located in Augusta, Georgia, under the direction of Doctor Gallaher, it is planned to utilize this form of therapy to rehabilitate patients with chronic obstructive lung disease. Doctor Gallaher plans to follow the regimen with oxygen ventilation treatment during exercise, as advocated by Beck.[7] Oxygen is passed through a double nasal canula attached to a length of rubber hose. Usually 6 to 8 liters per minute are used to begin with. The patient walks 100 steps with oxygen, followed by 50 steps without oxygen. Then daily this is increased, the number of steps with oxygen, and the number of steps without oxygen. The patient increases the number of steps to his maximal tolerance. Results of this method have been most encouraging and we hope to promote this form of therapy throughout our clinic system, once it is established.

Mechanical Ventilators

There are any number of mechanical ventilators on the market today. All of them do a certain job. None will suit the needs of all patients. In our clinic set-up, we are using the Bird Ventilator. We feel that it comes the closest to giving us what we want. At present, we have approximately 30 patients a day on a therapeutic regimen with the Bird Ventilator. The regimen in all cases is as follows:

We are using the Bird Mark 7 Respirator. Wetting agents used are water, 20 per cent alcohol, and 4 per cent saline solution. Micronephrin and Vapo-Enephrin, a 2.25 Racinic Enephrin are the bronchodilators. In each adult patient with any obstructive lung disease we use 4 cc. of 20 per cent alcohol and 4 drops of Micronephrin for each 15-minute treatment. The 20 per cent alcohol is obtained by diluting 80 proof Vodka with an equal quantity of water. In cases in which tremor is evidenced during therapy, the Micronephrin is reduced to 2 or 3 drops. The alcohol acts as a moistening agent on the secretions and the bronchial dilators loosen them, so that they can be coughed up.

In children with cystic fibrosis, we use 4 cc. of 4 per cent saline solution and 4 drops of Micronephrin. The saline draws the water from the bronchial walls, thereby loosening the tenacious secretions. Saline solution is used also in adult patients with extremely tenacious secretions. In several cases, Dornavac has been somewhat efficacious in aiding the removal of thick, tenacious secretions.

The patient is seated before the ventilator in a comfortable position and instructed to breathe in very slowly. He is encouraged to cough if he requires removal of secretions. He continues on the ventilator for a period of 15 minutes, three times a day. We have been astounded at the results obtained among our small group of patients on this regimen.

At the present time, one of our clinics is using only the Bird Ventilator with the above described program. If the patient has been on any medication prescribed by his referring physician, he is maintained on the same regimen during this period of treatment. After the patient has learned the use of the Bird Ventilator, he is encouraged to purchase one if he is financially able, and maintain this form of therapy at home. Many

of the patients are on combined medical, exercise, and Bird Ventilator therapy which we feel at the present time is the ideal approach in handling patients with chronic lung disease.

Results were considered excellent in those cases in which symptoms were relieved sufficiently to enable the patient to carry on his normal activities. In those in which relief of symptoms was sufficient to allow the patient to be up and about, the results were interpreted as good. In all cases in this first group, the disease was far advanced. The results are extremely encouraging.

Summary

Several regimens for the patient with chronic obstructive pulmonary emphysema are presented. It is our feeling that such patients can be managed best in group therapy clinics associated either with the hospital or the medical school, or other medical agency.

We hope to stimulate the continued increase in the number of clinics in our state through aid enlisted from the Georgia Department of Public Health and the Georgia Thoracic Society, the latter being the medical arm of the Georgia Tuberculosis Association.

It is our belief that the combined medical, exercise, oxygen breathing and pulmonary ventilatory regimen is the best method of maintaining chronic lung disease patients in a fair state of health.

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A Challenge for Leadership

The U. S. Public Health Service and the Office of Civil and Defense Mobilization in cooperation with the American Medical Association, the Council on National Security, and the Committee on Disaster Medical Care have announced the creation of the "Medical-Self Help Training Program." The urgency of this project is emphasized by the stark calculations that in the event of a massive attack upon our nation the magnitude of the casualties would reach such proportions that no amount of surviving professional aid could cope with the problem of emergency medical care. Therefore it seems clear that the alternative to total disaster lies in the training of the general population in the principles of first-aid, and more importantly, self-help.

There are many capable individuals among the lay public who have had much experience serving in the medical corps of the past wars. In addition, there are many others who through their continued contacts with the medical profession as aides, etc., possess the potential to develop, with proper training, into an efficient medical corps. These people could be instructed, for example, to carry out *extended* first-aid care such as the arrest of hemorrhage, maintenance of patent airway, emergency closure of sucking chest wounds, treatment of shock and burns, as well as countless other exigencies for which professional medical help might not be available for many days.

The Medical-Self Training program must reach some 60 million people without delay. This project can be achieved only if the entire medical profession supports it. Its scope requires the medical leadership on a national, state, county and individual basis. Its extreme urgency demands that we familiarize ourselves with this undertaking forthwith, and as it further develops.—Westchester Medical Bulletin.

Special Article

Microbiology, Research and Travel In Argentina and Europe

John M. Slack, Ph. D.

A year ago last February, my family and I boarded a plane in New York City bound for Buenos Aires. This was the beginning of a combined sabbatical leave from West Virginia University and an opportunity to study and do research with individuals in various countries who were interested in a group of micro-organisms called the microaerophilic Actinomyces. I have been working with these organisms some twenty years, particularly from an antigenic standpoint, and recently have been applying fluorescent antibody techniques in these studies.

We left New York City in near zero weather and 15 hours later landed in Buenos Aires with 80° F. weather. The city proved to be a modern, busy metropolis with an overall population in excess of six-million Spanish-speaking people. We were impressed with the modern shops, the colorful clothes, the attractive ladies and the traffic which moved with reckless abandon. On one of the picturesque main streets (Florida) the traffic hazard was overcome in that the street was open only to pedestrians. Food, living and transportation costs were most reasonable although the cost of clothes and appliances was extremely high.

In Buenos Aires I worked with Dr. Pablo Negroni at the University of Buenos Aires Medical School. Doctor Negroni is internationally recognized for his work in medical mycology, having published numerous papers on the subject and now being engaged in writing a series of authoritative books. When asked how he accomplished all this, he indicated that his day usually began at five in the morning.

Doctor Negroni's laboratories are in a medical center which, as in West Virginia, includes the schools of medicine, dentistry and pharmacy in one large multistoried building. An enormous university hospital of some 4,000 beds is under construction. The laboratories in the mycology division are most adequate, and an adjacent outpatient clinic affords an excellent opportunity for direct observation of patients with a wide variety of fungus diseases.

Submitted to the Publication Committee, February 13, 1962.

The Author

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The medical school accepts several hundred students as freshmen, and the teaching primarily is by lecture and demonstration methods. The students are enrolled for six years, spending part of their last two years on hospital assignments, and not serving internships.

From Buenos Aires we traveled to France via plane, ship and train and then by car to Milan, Italy. Milan is another large city, highly industrialized and prosperous. Sitting in a sidewalk cafe in the Galeria, which seems to be the center of activity, one senses an urgency of movement and purpose among the Northern Italians which was in direct contrast to the leisurely manners of the natives in Buenos Aires, in cafes on their Ninth of July Avenue.

At the University of Milan I worked with Dr. Elio Baldacci in his modern and well-equipped laboratories. Doctor Baldacci has contributed greatly to the establishment of internationally accepted principles of bacterial classification, and has worked for many years on the problems of the identification of the Streptomyces. He now is engaged in electron microscope studies of the latter.

On our way back to Paris we spent two weeks traveling in Italy and Switzerland. From Milan we drove south to Pisa where we saw one of the most impressive sights of the entire trip, the famous Leaning Tower, which sparkled in the sun among its trim and orderly surroundings. Then on to Rome where, by means of guided

tours, we rushed through Vatican City, The Colosseum, the Pantheon, the catacombs and many ancient churches. From Rome we went to the delightful city of Florence with its famous Uffizi Gallery and, finally, to Venice.

Although one has read about and seen pictures of Venice, he does not entirely appreciate the fact that here is a large city which depends entirely on water transportation. For instance, we watched with fascination a building being repaired, the sand, cement, stone, and lumber and cement mixer being brought by boat. Can you imagine taking a boat to cross a "street?"

Next came Switzerland with its rugged, snow-bound mountain ranges, green pastures, countless waterfalls, fat cattle and children with rosy cheeks. We stayed at an inn in the village of Oberwil and traveled from there to Zurich, Lucerne, Basel and Zermatt. Zermatt is a picturesque town close to the Matterhorn but to our disappointment the top of this famous mountain was obscured by clouds during our entire stay.

In Paris we were fortunate to find a small, reasonable hotel just off the Champs-Elysees close to the Arc de Triomphe. We spent many enjoyable evenings just walking along this avenue or sitting in one of the many sidewalk cafes. Using the metro, their subway system, we took weekend excursions which included the Eiffel Tower, the Louvre, Napoleon's tomb, Invalides, Notre Dame, the Flea Market and numerous other places of note.

In France, through the work of Louis Pasteur, microbiology became a well-established science. In Paris he did much of his work at l'Institut Pasteur and since its inauguration, in 1888, men such as Roux, Metchnikoff, Bordet, and others too numerous to list have continued to provide notable contributions to microbiologic science.

The Institut is housed in a number of buildings, some old and some very modern. It serves primarily as a research center but also produces a wide variety of biological products, particularly vaccines. Visitors should make a point of seeing the tomb of Pasteur as well as the very fine museum.

Here I had the pleasure of working with Dr. A. R. Prevot, one of the leading authorities on the Clostridium and a good friend of Dr. Robb Spalding Spray, who retired some years ago from this University. Doctor Prevot also has been interested in the Actinomyces and his extensive collection was made available to me for my work.

The last part of our trip was spent in Copenhagen, a city of over a million inhabitants, all riding bicycles. The people are most friendly and usually speak understandable English. Ships and the sea provide much of their livelihood and restaurants serve excellent sea food along with the numerous varieties of open-faced sandwiches. One of the principal attractions in Copenhagen is Tivoli with its pantomime theater, concert hall and amusements, all for the general admission price of fifteen cents. Here, from conversation and articles in the papers, we became aware for the first time of the impact of the European Common Market and the influence it will have on Europe in the years to come.

The famous Statens Seruminstitut in Copenhagen is comparable in function to our National Institutes of Health, being concerned primarily with research but also responsible for numerous biological products. The Institut covers several acres, with numerous laboratory buildings. I was particularly impressed with the latters' modern equipment and the work of their many fine investigators. The Institut has gained international recognition in microbiology and other health sciences.

I worked with Dr. Per Holm who, like all of the other men with whom I worked, was a tireless and devoted laboratory investigator. He has been interested in Actinomyces for many years, and I spent many profitable hours in his laboratory.

We returned home in August having a much greater appreciation of the customs, the problems and the people of Argentina and European countries. We will, however, always owe a debt of gratitude to West Virginia University for making this wonderful trip and research experience possible.

. . . at least once a year everybody is a genius.

G. C. Lichtenburg.

Special Article

Faith In Freedom*

The Rev. George H. Vick, D. D.

For twenty-five years I have served as a minister in the Presbyterian Church. During those years I have had the high privilege of knowing intimately many people. The doctors I have known have, with but few exceptions, been men of outstanding character, intellectual attainment, professional skill, personal integrity, and warm-hearted compassion. These men, known in various relationships in many parts of the United States for over a quarter of a century, are being unjustly maligned in our time. They are my friends and what hurts them, hurts me.

It is true that many of them disagree with the Administration's proposals, as contained in the King-Anderson Bill. They have repeatedly declared their support of the Kerr-Mills Bill which is current law. Because the medical profession will not support a particular method of accomplishing the end, which men of good will desire, their motives as well as their character are being attacked.

My friends of a lifetime, who were caring to the limit of their ability for the indigent aging long before those over 65 became politically valuable, are now accused of hard hearts and unworthy motives. I know what some of you have contributed in the past to the public welfare; and it hurts me for you as individuals and as a group to be characterized as the cruel and heartless ones. It seems to me that it is time for your friends who have known healing and compassion from your hands and hearts to speak up and to speak out.

This matter of unjust character assassination is not all or even most. There is the matter of freedom and personal responsibility as well as economic integrity. You are accused of meddling in politics. I know of nothing in the structure of our country that requires a man when he becomes a doctor to abdicate all or even part of the rights of his citizenship. You have rights other than the right to pay taxes. You have a right to speak; you have a right to be heard. These are your rights as Americans, and any one who would deny you these rights is less an American for it.

Things are topsy-turvy in a world in which politicians make medical pronouncements and doctors are told to be silent concerning economics, politics, and proper medical services. When a person becomes a doctor that person gives up neither his political freedom nor his economic integrity. Certainly a person need not be an expert in the field of finance to see that what is being proposed under Social Security is actuarially unsound; and at best, can only be characterized as economic frivolity.

In my profession we believe that in order to get a proper answer to the question, "Whence comes man's yearning for freedom?", it is necessary to go all the way back to God. It was God who set man free, to roam the earth, to live, to die, to build up, to tear down. God even provided that man be free to worship or not to worship the One who made him. At times we emphasize the point that man is just as free to go to Hell as he is to go to Heaven.

I am persuaded that what is being proposed will result, if enacted, in additional erosion of individual freedom. I believe that a man ought to have the right to prepare in his own way for the future. I believe that all of us together ought to make provisions for those who are unable or unwilling to make such preparations. I do not believe that it is in the service of freedom for us to be told that this way and this way only is acceptable and *all* must participate in a prescribed manner.

The Author

- **The Rev. George H. Vick, D. D., Atlanta, Georgia, former Pastor of the First Presbyterian Church in Charleston, and now serving as Executive Secretary of the Board of Annuities and Relief, Presbyterian Church in the United States.**

*Some excerpts from an address presented before a meeting of the Kanawha Medical Society in Charleston on June 12, 1962, and reprinted from the July issue of the Society's Newsletter.

In my lifetime it seems that more and more decrees as to what is good for us are being hatched from the active brains of men in Washington. (Often, after we are told what we must do, we are then told that this is what we wanted to do!) Many of these men seemed to be but common clay like the rest of us until the winning of an election (at times by a very narrow margin); and a brief journey to Washington seemed to endow them with almost divine power to discern what would constitute the general welfare.

Freedom is won or lost in not the so-called major happenings, but in the so-called minor ones. The major happenings (as in the case of the price controversy involving U. S. Steel) simply dramatize the score. They underline how far along the road we have traveled. I have never known an alcoholic whose plight resulted from just one drink. I have never known an alcoholic whose plight didn't begin with just one drink. History teaches that one must whittle a long time at little freedoms before a big tyranny can be established in the name of freedom or the public welfare.

People generally are not allowed to vote on the one big question as to whether or not they want freedom. They are only permitted to stand for it or against it in the little, seemingly harmless matters that usually are presented in the most attractive ways. I know of no one who is against medical care for the aging, especially the indigent aging. I know of many, including myself, who are opposed to providing it after the pattern of the King-Anderson Bill.

My friends, you have no right to be neutral when you believe that a principle is involved. A doctor who believes that one diagnosis is as good as another or one therapy is as good as another has no right to confidence or respect. A man who believes that the end justifies the means is immature in his evaluation of human history. A man who is clear in his head concerning his convictions ought to be hot in his heart as he seeks to persuade others.

Others will talk with you about the detailed facts that are involved. I talk with you about feelings. It is my prayer that you will always have strong feeling for freedom. The facts of history support such feelings.

Doesn't it strike you as strange that a program which is supposed to be so desirable and which offers such fantastic benefits at such incredible low cost demands so much selling? It could be that people are wiser than many in government believe them to be. It could be that the people sense that the ultimate price of the package is not clearly marked and, as yet, has not been fully revealed.

Building Our Characters

It should be our duty to stimulate the younger men to the full realization of the importance of devotion to duty and intellectual integrity. In training our young men, we should not only instill scientific knowledge, but we should also stress and teach the necessity of their becoming an integral part of the community in which they live and practice. We should not lose sight of the fact that what really counts in life is not how a man started, but how he finishes. A splendid training imposes great obligations, but if it merely brings a smug satisfaction of being superior, the training has failed. It has been said, "As a man thinketh, so is he." His constant thoughts and his earnest desires constitute his ideals. Unless a physician strives to do justly, to love mercy, and to walk humbly with his patient as well as with his fellowman, his skill and his learning are as a sounding brass and a tinkling cymbal. Efficiency without character is a poor staff upon which to lean.

We must learn to work and cooperate with our fellow practitioners. There is no greater waster of time nor consumer of energy than hatreds, vengeance, or a desire to get even for a real or fancied wrong. If the doctor's ideals are high, and he manfully tries to maintain them, these vices are kept under increasingly better control. It is a solemn thought that we do not stand still in building our characters. We will either make them better or worse.—Guy W. Horsley, M. D., in Virginia Medical Monthly.

Ethics

The behavior of an inanimate object can be predicted with complete accuracy if all data about its physical characteristics, its environment, and the forces applied to it are known. Such behavior cannot be influenced one iota by ideas, wishes, concepts, or concerns. Among plants and other organisms which lack a mind, a similar immunity from intellectual influence exists, although they do respond more obviously to a larger number of subtle influences—phototropism, for example. Among the higher animals intellectual and emotional factors—feels, if you will—begin to affect behavior. Thus a dog wags his tail at the sight of his master but growls at the hostile delivery boy.

Applied to man himself, these influences become so numerous and so intermingled that it is difficult to understand all of the factors which lead to any particular act. Thus weather, hunger, pain, greed, generosity, devotion, dishonesty, fatigue, comfort, anxiety, ambition, laziness, lust, education, ignorance, intelligence, hostility, happiness, and a thousand other forces become vectors, the sum total of which results in behavior. Much of the process of "civilization" has been an attempt to minimize the negative units of this complex. Most of the purposes of religion and education have been devoted to accentuating the positive forces in this conglomeration.

The concept of ethics, as far as we can be certain, is appreciated by man alone among the species. It is, perhaps, the one characteristic above all others which separates him from his animal cousins. The idea of ethics is something more than conformity to rules or obedience to the dictates of authority. It is a pattern of behavior in which devotion to "the highest good" becomes a force strong enough to overcome the multiple negative factors at work in determining one's performance in all matters—be they large or small. In the practice of medicine this force must of necessity be within the physician himself, for his work is usually done without the awareness of observers qualified to judge it adequately. As we examine a patient in the privacy of the examining room, who is to tell whether it is properly done? As we conjure with the problem of differential diagnosis, who is to gauge the thoroughness of our efforts? Only the most blatant deficiency can be detected by the untrained eye.

It, therefore, becomes part of the physician's responsibility to bring to bear upon each and every problem the sum total of his skill, training, and devotion without thought of public acclaim or approval. He must be his own harsh taskmaster and judge. He must place at the disposal of his patient all of his resources of body, mind, and spirit and reserve nothing because of apathy, greed, weakness, or expediency. At the same time, he must retain the humility that recognizes his debt to his teachers who gave him his knowledge, to the research men who developed his tools, and to the society that produced the schools and hospitals. He must recognize his function as a trustee to whom these assets are bequeathed in trust—to be passed on undiminished to his successors.

And, finally, he must recognize himself as a part of the profession, the magnificent tradition of which is dependent upon his daily performance for its perpetuation. If these concepts can be the central core of our daily modus operandi, then one need not be overly concerned about the proper interpretation of many items in the printed "codes of ethics" which surround us.—Perry S. MacNeal, M. D., in The Pennsylvania Medical Journal.

The President's Page

The Year Ahead

MAY I take this opportunity to express my appreciation and gratitude to the membership of the West Virginia State Medical Association in honoring me with the office of President. In accepting this office I fully realize the many responsibilities and duties which have come to me. The challenge will be great and the problems many, but I pledge to cope with them to the best of my ability. In order to do this I must ask for the cooperation of each member of the Association.

I am looking forward with a great deal of pleasure to working with our committees. Because of the tremendous importance attached to the duties of the committees, I urge the members of various committees to strive diligently to attend the meetings when they are called. By so doing, you will be rendering an invaluable service to the Association. With your advice and guidance we shall all be laboring toward a common goal: the betterment of our profession in West Virginia and the United States.

To my predecessor, Dr. D. E. Greeneltch, I wish to extend my appreciation and that of the entire membership, for a job well done. He has performed the duties of the office of President with great dignity and honor. He deserves the highest plaudits of Association members for his untiring labors.

I also wish to commend the various committees which served under him for their splendid accomplishments. Were it possible, I would like to commend each member individually for the many hours and tremendous effort which they expended to help Doctor Greeneltch.

The defeat of the Anderson-Javits Amendment in the Senate has killed for the present the efforts of the Administration to place medical care for the aged under Social Security. This action should not lull us to drop our guard. We should be vigilant at all times against the continuing efforts of those who would force a system of socialized medicine upon the United States by taking advantage of the American sympathy for the aged.

To quote from the inaugural address of the AMA President, Dr. George M. Fister: "We will not compromise with those who regard medical care problems as simply playthings in the game of politics—gimmicks to attract the votes of the gullible. But we will cooperate, to our utmost, with Government officials, legislators and all Americans in finding sound practical solutions to such problems—solutions which include both a respect for medical standards and a respect for the taxpayer."

L. J. Pace, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 343-4607.

EDITORIALS

EFFECT OF HYPOXIA AND OF ASPHYXIA ON THE CIRCULATION OF THE BRAIN

The circulation of the brain may be influenced by several intrinsic factors; among these are: (1) changes in the diameter of the blood vessels, which can be brought about by a decrease in oxygen tension, an increase in carbon dioxide tension, and by neurogenic control; (2) by the viscosity of the blood; and (3) variations in intracranial pressure. The regulation of blood flow through the brain is controlled chiefly by the oxygen tension and by the carbon dioxide tension in the blood. This was not fully appreciated until the work of Schmidt[1] and Wolff.[2]

Wolff pointed out many years ago that inhalation of carbon dioxide produces a greater vasodilatation of the vessels which supply the brain than does oxygen want. It appears, then, that asphyxia (a condition associated with an increase in carbon dioxide tension) produces a greater vasodilatation than hypoxia (a condition not associated with an increased carbon dioxide tension). Dumke and Schmidt,[3] however, in 1943 observed that both an increase in carbon dioxide tension and oxygen want produces an increased cerebral blood flow, but the latter condition produces the more striking effect. Be that as it may, both conditions are capable of significantly increasing the blood supply to the cerebrum.

The present consensus is that while relatively slight variations of oxygen tension do not affect cerebral blood flow, a moderate decrease in oxygen tension may produce a significant increase. Courtice,[4] working with anesthetized cats, reported that there was no significant change in cerebral circulation until the inspired air contained somewhat less than 15 per cent oxygen (about a partial pressure of oxygen of 67 mm. Hg). This corresponds roughly to an altitude of 9,000 feet.

Working with man, Kety and Schmidt[5] in 1948 observed that in subjects breathing 10-13 per cent oxygen (corresponding to altitudes of 19,000 to 13,000 feet respectively) the cerebral blood flow increased about 35 per cent. Recent work by Lassen[6] has confirmed these results. This latter worker has emphasized that the vasodilatory response to oxygen want means that a greater degree of arterial unsaturation can be tolerated than would be the case if this response did not occur. According to Lassen, therefore, the mechanism has a distinct protective function. This would indeed seem a logical supposition.

It has been reported by Opitz and Schneider[7] that during anemia the cerebral blood flow is also increased. Vasodilatation commences when the partial pressure of oxygen of the cerebral

venous blood falls to about 28 mm. Hg (normally it is 33 mm. Hg).

There is sound evidence, then, that during exposure to hypoxia, and also during anemic states (hemic hypoxia) there is an increased blood supply to the brain. This is an extremely important observation, and it presumably is the most significant intrinsic factor in the regulation of cerebral blood flow.

In spite of this helpful regulatory mechanism which occurs during hypoxia, nevertheless, beyond a certain threshold (probably about from 8,000 to 10,000 feet) the cerebral cortex commences to suffer from the effects of low oxygen tension. Moreover, it is generally recognized that during oxygen want, unfortunately, the brain is the first organ to be affected.

1. Schmidt, C. F., A. J. Physiol., 84:202, 1928.
2. Wolff, H. G., Physiol. Rev., 16:545, 1936.
3. Dumke, P. R., and Schmidt, C. F., Am. J. Physiol., 138:421, 1943.
4. Courtice, F. C., J. Physiol., 100:198, 1941.
5. Kety, S. S., and Schmidt, C. F., J. Clin. Invest., 27:484, 1948.
6. Lassen, N. H., Physiol. Rev., 39:183, 1959.
7. Opitz, E., and Schneider, M., Ergebn. Physiol., 46:126, 1950.

Basic Issues Are Real Threat

Doctors are held in high regard in their communities. You can be powerful supporters of the Constitution and of conservative government. To do this, however, you must be as informed on federal aid to education, labor legislation, foreign aid, and all other legislation as you are on medical care of the aging under social security. The battle you're fighting, if you fight only against this bill, is against only one of the symptoms. It isn't basic! It isn't logical! It isn't conclusive!

Every one of us was taught to get to the basic cause of diseases, and not to be concerned or led astray by the "red-herrings" of symptoms. The bill to place medical care under social security is spawned, is originated, is conceived by the same groups (and under the same philosophy) who want to give the federal government control and responsibility for housing, labor laws, and every phase of human endeavor from the cradle to the grave.

You are not being asked to leave your profession to join the battle. In fact, I don't necessarily recommend it. I ask only that you demonstrate the same sense of citizen's responsibility that seven of our colleagues showed 200 years ago when they signed the Declaration of Independence, and of the six who now serve in the House of Representatives.

The time has passed to think that we can save medicine while other institutions are falling around us. The time is here when you must become the precinct captains, the men—or women—who ring doorbells on behalf of the political party or the committeemen for the candidates you help to select.

If you delay you will, one day, be reminded of the statement of Dante: "The hottest places in hell are reserved for those who, in time of moral crisis, did nothing."

The effort to fight socialism *is* worth it to *you*. It's worth it to *us*. It's worth it to our country.—Durward G. Hall, M. D., in Texas State Journal of Medicine.

Mail Order Medication

As physicians, we scorn diagnosis or treatment through the post office. A similar attitude should lead us to question the filling of our prescriptions by mail order. The postal pharmacist must either assume that the signer of the prescription is an authorized physician; or he has to invest time, expense and trouble in finding out. If the drug retailer is in another state, he is immune to the safety regulations governing dispensing in the doctor's own state. Even the speediest postal service is slower than the traditional over-the-counter method. Every medical practitioner has had occasion to thank some pharmacist for calling him up to verify a dosage or a drug name. This kind of courtesy—or precaution—is impossible by remote control. The reciprocally helpful relations between physician and pharmacist will never flourish where their only bond is a postage stamp. You do not know anything of the professional qualifications of the man who fills the prescription in a distant state. It is almost impossible to check on errors, brand substitutions, or other sources of dissatisfaction by a postal complaint, whereas the local pharmacist is there, and is going to be there quite a while. If the mail order pharmacist can charge less, it is only because he can fill prescriptions in such huge quantities as to make lower prices economically possible. But here is one area where a belt-line, mass-production operation is not desirable.

The patient may not ask us—or tell us. But if he does, we ought to remind him that there is a real advantage in having a neighborhood pharmacist who maintains prescription files and gets to know the patient and the doctor. No one knows whether mail order drugs are really cheaper. Even if they are, cheapness is not our prime requirement here. Some things are more important than price.—The Journal of the Medical Society of New Jersey.

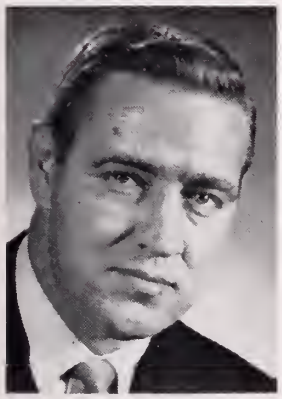
There's a Difference in Drugs

During the Kefauver Subcommittee's investigation of the prescription drug industry, over and over again, it was said that "generic equivalents" will give the American people the same top quality of medicine that is provided today by brand-name drugs. Is that statement true? Preparations of the same medicine made by different manufacturers are almost certain to be different. Differences in production methods, in the size of particles and in the type of binder or of coating can make marked differences in the drug's effects on the patient.—Journal of Iowa Medical Society.

GENERAL NEWS

15th Annual Rural Health Conference At WVU Medical Center

The 15th Annual Rural Health Conference will be held at the West Virginia University Medical Center in Morgantown on Thursday, October 4. The theme for the meeting, which will be attended by representatives of farm groups and others interested in rural health, will be "The Program at the West Virginia University Medical Center and How it Benefits the Rural Areas of the State."



Norman Laughlin

Conferences in previous years have been held at Jackson's Mill and it is expected that the 1963 meeting will once again be held there. Dr. Martha J. Coyner of Harrisville, who is in charge of the program for this year's Conference, announced that the meeting will be held at the Medical Center this year to provide an excellent opportunity for many persons residing in the rural areas to tour and view the Medical Center in actual operation.

The Conference is sponsored annually by the State Medical Association in cooperation with the West Virginia Home Demonstration Council, Agricultural Extension Division of West Virginia University, the State Department of Health, the West Virginia Farm Bureau and the West Virginia Congress of Agriculture.

Addresses by Drs. Sleeth and Penrod

Doctor Coyner will call the meeting to order in the auditorium at the Medical Center promptly at 10:00 A. M. Following the invocation and opening remarks by Doctor Coyner, the program will be turned over to Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine, and Dr. Kenneth E. Penrod, Vice President of the Medical Center.

Doctor Penrod will outline the general operation of the Medical Center and Doctor Sleeth will discuss specific items which will be of interest to the guests at the meeting. Following their remarks, there will be a guided tour of the Medical Center. It is hoped that it will be possible for third and fourth year medical students to serve as guides.

Luncheon will be served in the cafeteria at noon, with the West Virginia State Medical Association as host.

Afternoon Session

Dr. L. J. Pace of Princeton, President of the West Virginia State Medical Association, will deliver the address of welcome at the opening of the afternoon session.

The principal speaker at the afternoon session will be Mr. Norman Laughlin of Fairmont, Manager of the Upper Monongahela Valley Association. His subject will be "What the Community and Its Citizens Can Do to Encourage Physicians to Practice in Rural Areas."

A native of Fairmont, Mr. Laughlin attended the public schools in that city and was graduated from West Virginia University in 1943. He served with the United States Army in the European Theatre of Operations during World War II.

He assumed the editorship of the *Spencer Times Record* in 1946 and, except for brief interruptions, served as editor until he was named to his present position in 1959.

Following Mr. Laughlin's address, there will be a question and answer period with full audience participation. Doctor Coyner will serve as moderator. The Conference will be adjourned at 2:30 P. M.

The Conference is open to members of all interested groups, and a formal invitation to attend the one-day meeting is being extended to members of local farm bureaus, home demonstration councils, agricultural extension workers, and personnel of the state and local health departments.

Dr. Martha J. Coyner of Harrisville and Dean Clark K. Sleeth of Morgantown met recently to discuss plans for the 15th Annual Rural Health Conference which will be held at the West Virginia University Medical Center on October 4. Doctor Coyner is in charge of arrangements for this year's meeting.

Seventh Annual Postgraduate Institute At Martinsburg, Sept. 13-16

Thirty prominent physicians and scientists will appear as guest speakers at the Seventh Annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, September 13-16.

The meeting is sponsored jointly by the Eastern Panhandle Medical Society and the West Virginia Chapter of the American Academy of General Practice. Members of the American Academy of General Practice will be granted 18½ hours of Category One Credit for attendance at the meeting.

Morris Fishbein, M. D.

Chauncey D. Leake, Ph. D.

Dr. Karl P. Link of Madison, Wisconsin, Dr. Morris Fishbein of Chicago and Dr. Chauncey D. Leake of Columbus will be guest speakers at dinner meetings which will be held on Thursday, Friday and Saturday evenings.

Dr. Halvard Wanger of Shepherdstown, the general chairman, said scientific and industrial exhibits will be housed in the Shenandoah Hotel and the scientific sessions will be held in the Apollo Theater.

Thursday Afternoon Session

The first scientific session will be held on Thursday afternoon, September 13, at which time the following program on Surgery will be presented:

"Pancreatic Tumors."—Robert J. Coffey, M. D., Professor and Head of the Department of Surgery, Georgetown University School of Medicine, Washington, D. C.

"The Controversy About Treatment of Carcinoma of the Breast."—Warfield M. Firor, M. D., Professor of Surgery, Johns Hopkins University School of Medicine, Baltimore.

"Right-Sided Colonic Pain With Left-Sided Lesion."—Manuel E. Lichtenstein, M. D., Professor of Surgery, Cook County Graduate School of Medicine, and Associate Professor of Medicine, Northwestern University Medical School, Chicago.

"Diagnosis and Surgical Treatment of Renal Vascular Hypertension."—John D. Young, Jr., M. D., Professor and Head of the Department of Urology, University of Maryland School of Medicine, Baltimore.

Panel Discussion—Bernard Zimmermann, M. D., Professor and Chairman of Surgery, West Virginia University School of Medicine, Moderator.

Address by Dr. Karl P. Link

Dr. Karl P. Link, Professor Emeritus of Biochemistry at the University of Wisconsin, will be the speaker at the dinner on Thursday. His subject will be "Freedom and the Brave Heart."

Physicians and their wives are invited to attend the "Hill of Glory," outdoor spectacular in Hagerstown, Maryland, on Thursday evening.

Friday Morning Session

The morning session on Friday will be devoted to basic science, obstetrics and gynecology. The speakers and their subjects will be as follows:

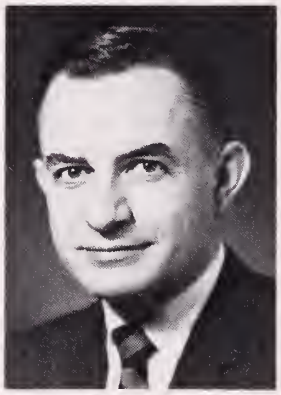
"The Thyroid Nodule — Physiological Puzzle."—Thomas H. McGavack, M. D., Professor Emeritus of Clinical Medicine, New York Medical College, and Professorial Lecturer, George Washington University School of Medicine.

"Lymphatics of the Female Pelvic Viscera."—Robert J. Johnson, M. D., Professor and Chairman, Department of Gross and Neurological Anatomy, West Virginia University School of Medicine.

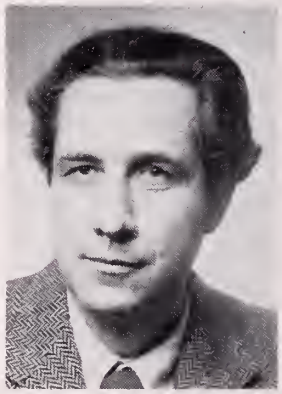
"The Early Recognition of Dystocia."—Frank D. Kaltreider, M. D., Professor of Obstetrics and Gynecology, University of Maryland School of Medicine, Baltimore.

"Gynecological Aspects of Obstetrical Delivery."—Milton L. McCall, M. D., Professor and Chairman of the Department of Obstetrics and Gynecology, University of Pittsburgh School of Medicine.

"Gynecological Problems in the Patient Over 60."—Thaddeus L. Montgomery, M. D., Professor and Chairman Emeritus, Department of Obstetrics and Gynecology, Jefferson Medical College, Philadelphia.



Richard C. Bates, M. D.



Karl P. Link, Ph. D.

"Hypertensive Emergencies in Obstetrical and Medical Patients."—John H. Moyer, M. D., Professor and Chairman of the Department of Medicine, Hahnemann Medical College and Hospital, Philadelphia.

Panel Discussion—Nicholas W. Fugo, M. D., Professor and Chairman of the Department of Obstetrics and Gynecology, West Virginia University School of Medicine, Moderator.

Afternoon Session

There will be a round table discussion at the luncheon at noon on Friday. The discussion leader at each table of eight will be a speaker or other authority. The

afternoon session will be devoted to medicine. The speakers and their subjects will be as follows:

"The Management of Seizures."—Bernard J. Alpers, M. D., Professor and Head of the Department of Neurology, Jefferson Medical College, Philadelphia.

"The Management of Coronary Heart Disease."—John M. Evans, M. D., Associate Professor of Medicine, George Washington University School of Medicine, Washington, D. C.

"Medical Aspects of Alcohol."—Chauncey D. Leake, Ph. D., Professor of Pharmacology Emeritus, Ohio State University School of Medicine.

"Some Art and Science in the Development of the Anticoagulant, Dicumerol."—Karl P. Link, Ph. D., Professor of Biochemistry Emeritus, University of Wisconsin, Madison, Wisconsin.

Panel Discussion—Clark K. Sleeth, M. D., Dean, West Virginia University School of Medicine, Moderator.

Dr. Chauncey D. Leake Dinner Speaker

Dr. Chauncey Leake, Professor of Pharmacology Emeritus, Ohio State University School of Medicine and Coordinator of Medical Research, University of California, will be the speaker at a dinner on Friday evening. His subject will be "Medicine and Survival."

Saturday Morning Program

The Saturday morning session will be devoted to basic science and medicine. The program follows:

"Pharmacology and the Development of New Drugs."—Daniel T. Watts, Ph. D., Professor and Chairman, Department of Pharmacology, West Virginia University School of Medicine.

"Use and Abuse of Barbiturates."—Theodore Koppanyi, Ph. D., Professor and Head of Department of Pharmacology, Georgetown University School of Medicine, Washington, D. C.

"Diagnosis by Clinical Examination."—Clark K. Sleeth, M. D., Dean of West Virginia University School of Medicine.

"Long Term Therapy of Chronic Respiratory Diseases With Steroids."—Leslie N. Gay, M. D., Associate Professor of Medicine Emeritus, Johns Hopkins University School of Medicine, Baltimore.

"The Response of Cells to Drugs."—John C. Krantz, Ph. D., Professor and Head of the Department of Pharmacology, University of Maryland School of Medicine.

"The Management of the Complications of Hepatic Diseases.—Charles M. Thompson, M. D., Professor and Head of the Department of Gastroenterology, Hahnemann Medical College and Hospital, Philadelphia.

Afternoon Program

The following program on medicine will be presented on Saturday afternoon:

"Do's and Don'ts in Geriatrics."—Thomas H. McGavack, M. D., Associate Chief of Staff, VA Center, Martinsburg.

"Selection of Rheumatic Heart Disease Patients for Cardiac Surgery."—Leonard Scherlis, M. D., Associate Professor of Medicine, University of Maryland School of Medicine.

"Long Term Anticoagulant Therapy for the Prevention of Coronary Thrombosis."—Benjamin Manchester, M. D., Assistant Professor of Medicine, George Washington University School of Medicine.

Convention Story Will Appear In October Journal

The 95th Annual Meeting of the West Virginia State Medical Association was being held at The Greenbrier in White Sulphur Springs as this issue of *The Journal* went to press.

The full convention story, including information concerning new officers of both the State Medical Association and Auxiliary, as well as heads of sections and affiliated societies and associations, will be carried in the October issue.

"New Perspectives in Diabetes Mellitus."—H. St. George Tucker, M. D., Associate Professor of Medicine, Medical College of Virginia, Richmond.

'Current Proposals for Medical Care'

Dr. Morris Fishbein of Chicago, contributing editor to *Postgraduate Medicine*, official Journal of the Interstate Postgraduate Medical Association, will be the speaker at the banquet on Saturday evening. His subject will be "Current Proposals for Medical Care."

Physicians and their wives are invited to attend a dance that evening. Music will be furnished by Russ Lang's Orchestra of Washington.

Sunday Morning Session

The Sunday morning session will be devoted to basic science and pediatrics. The program follows:

"Health Aspects of Radioactive Fallout."—Reginald F. Krause, Ph. D., Professor and Chairman, Department of Biochemistry, West Virginia University School of Medicine.

"Angiotension."—John C. Rose, M. D., Professor and Chairman, Department of Physiology and Biophysics, Georgetown University School of Medicine, Washington, D. C.

"Common Pediatrics Problems."— William J. H. DeMaria, M. D., Associate Professor of Pediatrics, Duke University School of Medicine.

"Cardiac Failure in Infancy."—Carolyn Moore McCue, M. D., Associate Professor of Pediatrics, Medical College of Virginia, Richmond.

"Obstructive Respiratory Syndromes of the Newborn."—Alexander J. Schaffer, M. D., Associate Professor of Pediatrics, Johns Hopkins University School of Medicine.

Address by Richard C. Bates

Richard C. Bates, M. D., Lansing, Michigan, cardiologist, will address the Sunday luncheon session on "How to Have a Heart Attack."

Physicians and their wives are invited to attend the reenactment of the Battle of Antietam Sunday afternoon in Sharpsburg, Maryland. Bus transportation will be provided.

The registration fee is $25 for the entire four-day course and $10 for a single day. Further information may be obtained by writing to Halvard Wanger, M. D., General Chairman, Box 175, Shepherdstown, West Virginia.

W. Va. TB and Health Assn. Meeting In Beckley, October 9-11

Two scientific programs of interest to physicians will be presented in connection with the Annual Meeting of the West Virginia Tuberculosis and Health Association and the West Virginia Thoracic Society which will be held at the Beckley-Winn Hotel in Beckley, October 9-11.

Dr. Charles E. Andrews of Morgantown will preside at a postgraduate course on "Current Concepts of Pulmonary Diseases" which will be held on October 9. The course will be sponsored by the West Virginia University School of Medicine and the Tuberculosis and Health Association and Thoracic Society.

William E. Ruth, M. D.

William W. Stead, M. D.

The following out-of-state speakers will present papers at the one-day meeting: Dr. William E. Ruth of Kansas City, Assistant Professor of Medicine at the University of Kansas School of Medicine; and Dr. William W. Stead, Associate Professor of Medicine at Marquette University School of Medicine.

The scientific program for the morning session will be as follows:

"Tuberculosis and Silicosis."—Werner A. Laqueur, M. D., Beckley Memorial Hospital, Beckley.
"Diagnosis and Management of Patients with Bronchitis."—William E. Ruth, M. D.

Dr. Bernard Zimmermann, Professor and Chairman of the Department of Surgery at West Virginia University School of Medicine, will serve as moderator for the afternoon session. The speakers and their subjects will be as follows:

"Studies on Pneumoconiosis."—Albert D. Kistin, M. D., Beckley Memorial Hospital, Beckley.
"'Organic' Pneumoconiosis."—William E. Ruth, M. D.
"Lung Biopsy in the Diagnosis of Pulmonary Disease."—Bernard Zimmermann, M. D.
"Modern Concepts in the Management of Tuberculosis."—William W. Stead, M. D.

A question and answer period will be held following the formal presentation of papers.

There will be a $10 registration fee in connection with the postgraduate course.

Thoracic Society Meeting

Dr. Richard V. Lynch, Jr., of Clarksburg, will preside at the meeting of the West Virginia Thoracic Society which will be held on October 10. Doctors Ruth and Stead will present papers and another out-of-state speaker will be Dr. William S. Blakemore, Professor of Surgery at the University of Pennsylvania School of Medicine.

The speakers and their subjects at the morning session will be as follows:

"Carcinoma of the Lung—The Problem."—William W. Stead, M. D.
"Factors in the Prognosis of Carcinoma of the Lung."—William S. Blakemore, M. D.
"Medical Management of Cancer of the Lung."—William E. Ruth, M. D.
"Surgery for Obstructive Emphysema."—William S. Blakemore, M. D.

A question and answer period will conclude the morning program.

Doctor Andrews will serve as moderator for a symposium which will be presented during the afternoon session. The other participants will be Dr. Preston C. Davis of Beckley and Doctors Ruth, Stead and Blakemore.

The annual business meeting of the West Virginia Thoracic Society will be held following the afternoon scientific session.

Medical Meetings, 1962

The following is a partial list of national, state and district medical meetings scheduled for 1962:

Sept. 9-15—Dermatology Congress, Washington.
Sept. 13-16—PG Institute, Martinsburg.
Sept. 17-20—American Hospital Assn., Chicago.
Sept. 20-21—W. Va. Heart Assn., Morgantown.
Sept. 22—W. Va. Diabetes Assn., Morgantown.
Oct. 1-4—Interstate PG Assembly, Chicago.
Oct. 4—Rural Health Conference, Morgantown.
Oct. 4-6—Congress on Mental Illness, Chicago.
Oct. 9-11—W. Va. TB and Health Assn., Beckley.
Oct. 15-19—ACS Clinical Congress, Atlantic City.
Oct. 22-23—American Cancer Soc., New York.
Nov. 2-4—ACP Regional Meeting, White Sul. Springs.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 24-25—ACCP, Ambassador Hotel, Los Angeles.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.

New Films Available

Three new films produced by Ayerst Laboratories are now available for showings before county medical societies. The 30-minute films are "Atherosclerosis and the Role of Estrogens," Hemostasis and the Effect of Estrogens," and "The Menopause and the Role of Estrogens."

The films may be obtained by writing the Film Division, Ayerst Laboratories, 685 Third Avenue, New York 17, New York.

Dr. G. Ralph Maxwell Reelected

Dr. G. Ralph Maxwell of Morgantown was reelected Governor of the West Virginia Chapter of the American College of Chest Physicians at the recent Annual Meeting of the ACCP in Chicago.

Dr. John F. Briggs of St. Paul, Minnesota, was elected president during the five-day meeting. He succeeds Dr. Hollis E. Johnson of Nashville, Tennessee.

American Heart Association Meeting In Cleveland, Oct. 26-28

Programs on clinical cardiology have been planned in connection with the Annual Scientific Sessions of the American Heart Association which will be held in the Public Auditorium in Cleveland, Ohio, October 26-28.

The clinical sessions will run simultaneously with the regular scientific sessions and programs dealing with special aspects of cardiovascular research. Each clinical session will include the presentation of original clinical investigative work, panels, symposia and lectures.

The annual meeting of the Association's Council on Arteriosclerosis will be held at the Hotel Manger in Cleveland, October 24-25. Dr. Eugene M. Landis of Harvard University will deliver the Lyman G. Duff Memorial Lecture.

Registration and hotel reservation forms may be obtained by writing the West Virginia Heart Association, Box 5336, Capitol Station, Charleston, West Virginia.

Conference on Occupational Health In Boston, Oct. 2-3

The 22nd AMA Conference on Occupational Health will be held at the Somerset Hotel in Boston, Massachusetts, October 2-3.

There will be no registration fee and all persons interested in occupational health are invited to attend. The annual award of the President's Committee on Employment of the Handicapped will be presented during the Congress program.

Further information concerning the program may be obtained by writing the AMA Council on Occupational Health, 535 N. Dearborn Street, Chicago 10, Illinois.

PG Course in Thoracic Diseases

A postgraduate course in Thoracic Diseases planned especially for the practicing physician will be held at the Ohio State University Health Center in Columbus, September 28-29.

The course has been designed to provide the physician in general practice with current concepts of pulmonary disease with emphasis on practical aspects of diagnosis and treatment.

Further information concerning the program may be obtained by writing Dr. John A. Prior, 1645 Neil Avenue, Columbus 10, Ohio.

Ob.-Gyn. District Meeting in Charlotte

The Annual Meeting of District IV of the American College of Obstetricians and Gynecologists will be held at the Barringer Hotel in Charlotte, North Carolina, October 4-6.

Information concerning the program may be obtained by writing Dr. Lawrence L. Hester, Jr., 55 Doughty Street, Charleston 16, South Carolina.

Dr. Mildred Mitchell-Bateman Named Acting Mental Health Director

Dr. Mildred Mitchell-Bateman has been named by Governor W. W. Barron as Acting Director of the Department of Mental Health. She succeeds the late Dr. Charles A. Zeller, who died on June 16 while attending a meeting in Williamsburg, Virginia.

Doctor Bateman is the second woman to serve in an acting capacity as head of the state agency. The other was Dr. Margaret T. Ross of Charleston.

A native of Cordele, Georgia, Doctor Bateman was supervisor of the Division of Professional Services in the Department of Mental Health prior to her appointment.

She was graduated from Johnson C. Smith University and received her M. D. degree in 1946 from the Woman's Medical College of Pennsylvania.

Doctor Bateman interned at the Harlem Hospital in New York City, 1946-47. She entered private practice in 1947 and twice served as Clinical Director at Lakin State Hospital, 1951-52, and 1955-58.

In 1955, she completed a three-year residency and fellowship at the Menninger School of Psychiatry in Topeka, Kansas. In 1957, she was certified by the American Board of Psychiatry and Neurology. Doctor Bateman became acting superintendent at Lakin State Hospital in June, 1958, and later that same year was named superintendent. She retained that position until August, 1960, when she joined the saff of the Department of Mental Health.

She is married to William L. Bateman and they have one daughter.

GP Meeting in Hagerstown, Maryland

The 14th Annual Scientific Assembly of the Maryland Academy of General Practice will be held at the Hotel Alexander in Hagerstown, October 13-14.

Dr. Edward Henderson of Montclair, New Jersey, will be among thirteen prominent physicians and surgeons who will present papers during the two-day meeting. Doctor Henderson, who is Editor of *The Journal of the American Geriatric Society*, will speak on "Medical Problems of the Aging Patient."

Further information concerning the program may be obtained by writing Mr. William J. Wiscott, Executive Secretary, 3722 Greenmount Avenue, Baltimore 18, Maryland.

AMA Film Catalogue Now Available

The 1962 edition of the AMA Medical Health Film Library catalogue is now available for distribution by the Medical Motion Pictures and Television Section of the Department of Scientific Assembly. The expanded catalogue contains information about 173 films for professional audiences and 82 films to be used by physicians in addressing lay groups.

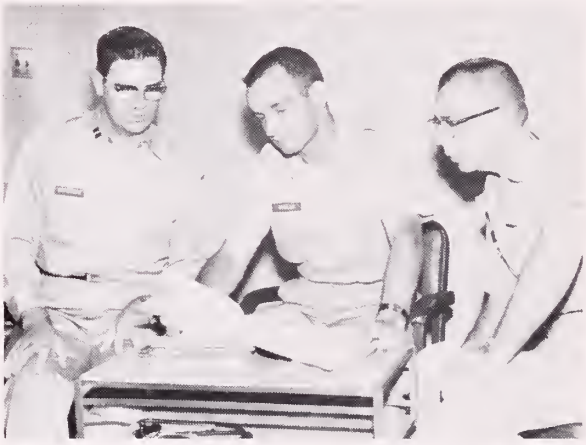
Films may be obtained, without charge, by addressing requests to the American Medical Association, Medical Motion Pictures and Television Section, Department of Scientific Assembly, 535 North Dearborn Street, Chicago 10, Illinois.

Three West Virginia Physicians Complete NG Service

Three West Virginia physicians called to active duty last fall with the 150th Armored Cavalry Regiment of the West Virginia National Guard returned to their practices in August.

Drs. William S. Sadler, Michail Dolgovskij and H. Summers Harrison were among the nearly 3,000 men recalled with the National Guard unit and stationed at Fort George G. Meade, Maryland.

The regiment underwent constant training. This included several weeks of intensive combat training and



These West Virginia physicians returned to their civilian practices in August. Drs. H. Summers Harrison, William S. Sadler and Michail Dolgovskij, left to right, were called to active duty last fall with the 150th Armored Cavalry Regiment of the West Virginia National Guard.

a month-long amphibious exercise at Fort Miles, Delaware.

The three physicians operated the regiment's dispensary, examining and treating an average of about 100 patients daily and assumed responsibility for the health of the entire regiment.

Temporary duty assignments also took Majors Sadler and Dolgovskij and Captain Harrison to Camp Pickett, Virginia, and Fort Miles.

Doctor Sadler practiced in Barboursville prior to the activation of the National Guard unit, Doctor Dolgovskij at Glen Dale in Marshall County, and Doctor Harrison at Summersville.

Subjects Announced for Annual Caleb Fiske Prize

The subjects have been announced for this year's Caleb Fiske Prize of the Rhode Island Medical Society —America's oldest medical essay competition. Physicians throughout the country are eligible to participate and a cash prize of $500 will be awarded to the winner.

The subjects chosen are "Etiological Factors in the Development of Congenital Anomalies," and "Progress in the Relief of Hearing Defects."

Entries on either subject must be typewritten, double spaced and should not exceed 10,000 words. Essays must be submitted by December 11, 1962, to the Secretary, Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

Better Control Measures Sought For Communicable Diseases

Local health officials and practicing physicians have been urged to cooperate in an effort aimed at better control of communicable diseases. State Director of Health N. H. Dyer said recently that many endemic diseases, including syphilis, tuberculosis, whooping cough, influenza, measles and chickenpox, are on the increase in West Virginia over last year.

He also reported that the State continues to experience a high incidence of German measles, mumps, streptococcal infections and gastroenteritis. Doctor Dyer said he also is "concerned" over the chance of an outbreak of rabies in humans because of an increasing number of animal bites, coupled with a high number of cases of rabies in wildlife.

Reporting Said Poor

Writing in a recent issue of the health department's "State of the State's Health", he scored local health officials for failure to report on communicable diseases. Nineteen counties were listed in the "nothing to report" category and eight others as "no report received" for a recent one-week period, the director of health observed. He said that "something is badly amiss" and that either local health departments are not receiving data from physicians or that the county units are not making a proper effort to obtain necessary control information.

Primary responsibility for collecting data lies with health departments, Doctor Dyer added, and proper procedures should be instituted at once to remedy the situation, where needed. He noted that only 25 typhoid carriers are registered with the health department while the number actually in the state probably numbers between 475 and 950.

Three Recommendations Offered

For better control measures, he offered three recommendations:

1. Better reporting. If necessary, he suggested a weekly poll of physicians by local health units and an educational effort through component societies.

2. More attention to specimens. He said it is "difficult and often impossible" to obtain proper specimens for analysis by the State Hygienic Laboratory. Using the oral polio vaccine, which has been stockpiled for epidemic situations by the Public Health Service as an example, he said prompt isolation of the type of virus is essential for effective mass immunization.

3. Sampling surveys. In order to determine the prevalence of communicable diseases in a community, he suggested that local health departments conduct surveys as the basis for possible immunization drives to "wipe out" polio, diphtheria, whooping cough and tetanus. He said the information obtained could also be used for better control of other diseases.

Doctor Dyer deplored a tendency toward "laxity" in communicable disease control and cited outbreaks of polio, meningococcal meningitis, infectious hepatitis and other diseases as examples that "the battle is never won."

W. Va. Heart Association Schedules Annual Meeting In Morgantown

The annual meeting of the West Virginia Heart Association will be held at the West Virginia University Medical Center in Morgantown on Friday, September 21. Dr. Morris H. O'Dell of Charleston, the president, has extended a cordial invitation to all physicians practicing in West Virginia to attend the meeting.

Dr. J. Keith Pickens of Clarksburg, the president elect, will preside at both the morning and afternoon scientific sessions. The morning program will get under way at nine o'clock and the afternoon session at 1:30 o'clock.

Luncheon will be served in the Medical Center Cafeteria at 11:30 o'clock followed by a membership meeting in the Auditorium. An awards banquet will be held at the Morgantown Country Club on Friday evening. Physicians and their wives attending the meeting also are invited to attend the West Virginia-Vanderbilt University football game on Saturday afternoon, September 22.

The speakers for the Friday morning scientific session will be members of the faculty of the Hahnemann Medical College and Hospital in Philadelphia. Their subjects are as follows:

"Renal Vascular Disease as a Cause and Complication of Hypertension."—Charles Heider, M. D., Research Fellow.

"The Role of Salt in Hypertension and the Use of Diuretics in Treatment."—Robert A. Seller, M. D., Director of the Diuretic Clinic.

"The Management of Hypertension."—Albert N. Brest, M. D., Hypertension and Renology Section.

Dr. John H. Moyer, Professor and Chairman of the Department of Medicine, Hahnemann Medical College, will serve as moderator of a panel discussion at the conclusion of the morning session.

The theme of the afternoon scientific session will be "Newer Concepts of Cerebrovascular Disease." It will consist of a panel presentation and discussion on (1) Cerebral Circulation—Anatomy and Physiology; (2) Cerebrovascular Accidents—Diagnostic and Pathologic Consideration; and (3) Medical and Surgical Management of the Stroke Patient.

Those participating in the panel will be members of the faculty of the West Virginia University School of Medicine. They are Drs. Byron M. Bloor, Professor and Chairman of the Division of Neurological Surgery; John W. Nelson, Assistant Professor of Medicine and Chairman of the Division of Neurology; and G. Robert Nugent, Assistant Professor, Division of Neurological Surgery.

A non-medical session also will be held on Friday afternoon with Mrs. Frank Harris of Kenova, chairman of the non-medical committee presiding. Dr. Margaret Albrink, Associate Professor of Medicine at the WVU School of Medicine, will speak on "Diet Obesity and Cardiovascular Disease."

Dr. Perry E. Gresham, President of Bethany College, will be the speaker at the awards banquet which will be held at the Morgantown Country Club on Friday evening.

In addition to Drs. O'Dell and Pickens, other officers of the Association are as follows:

Dr. Otis G. King of Bluefield, vice president; Mrs. Mary Savage of Vienna, secretary, and Miss Mary Helen Thompson of Charleston, treasurer. The executive director is Robert M. Simons of Charleston.

Further information concerning the program may be obtained by writing the West Virginia Heart Association, Box 5336, Capitol Station, Charleston, West Virginia.

Regional PG Symposium Planned In Buckhannon on Sept. 20

A regional meeting sponsored by the Central West Virginia Medical Society and the West Virginia Chapter, AAGP, will be held at the Buckhannon Country Club in Buckhannon on Thursday, September 20.

Thomas A. Loftus, M. D.

Physicians have been extended a cordial invitation to play golf at the country club during the morning hours. There also will be an entertainment program for wives of visiting physicians.

Members of the faculty of the West Virginia University School of Medicine will present the scientific program which will begin at 2 P. M. The speakers and their subjects are as follows:

"Role of the General Practitioner in Psychiatry."—Thomas A. Loftus, M. D., Professor and Chairman of the Department of Psychiatry.

"Dermatologic Manifestations of Systemic Diseases."—William A. Welton, M. D., Assistant Professor of Medicine and Chairman of the Division of Dermatology.

"Management of Postpartum Hemorrhage."—Dean Goplerud, M. D., Instructor in Obstetrics and Gynecology.

There will be a question and answer period following the presentation of scientific papers.

Dr. Clark K. Sleeth, Dean of the WVU School of Medicine, will be the principal speaker at the banquet which will begin at six o'clock. The banquet will be preceded by a social hour.

Physicians planning to attend the banquet should contact Dr. J. C. Huffman, Edmiston Building, Buckhannon, W. Va.

Relocation

Dr. John D. German, formerly chief of surgery and senior surgeon at Man Memorial Hospital, has accepted appointment as associate chief of surgery at the VA Hospital in Pittsburgh. He also will serve as assistant professor of surgery at the University of Pittsburgh School of Medicine.

Two WVU Physiologists Attend Meetings In Europe

Two physiologists from the West Virginia University School of Medicine will present papers at two International meetings this month in Europe. They are Dr. E. J. Van Liere and Dr. J. Clifford Stickney, who have collaborated in research at WVU since 1940.

Doctor Van Liere, Dean Emeritus of the School of Medicine, will discuss "Differences in Cardiac Hypertrophy in Exercise and Hypoxia" at the International Congress of Physiological Science at Leiden, The Netherlands, September 10-17.

His paper deals primarily with enlargement of the heart of test animals during periods of "oxygen want" or hypoxia. Such conditions were caused in the animals by subjecting them to high altitude conditions in a test chamber.

Doctor Stickney will present a paper on "Erythropoietin in Goats at Simulated High Altitude" before the Symposium on the Physiological Effect of High Altitude at Interlaken, Switzerland, September 18-22.

His paper will deal with experiments exposing mother goats to high altitude, then feeding their milk to kids which were not exposed to the same conditions. He noted that the infants developed the same adaptive changes to the altitude as their mothers, which included an increased number of red blood cells.

Dr. Lowell T. Coggeshall Heads Commission on Drug Safety

Dr. Lowell T. Coggeshall of Chicago, vice president of the University of Chicago, has been named chairman of the prescription drug industry's Commission on Drug Safety.

Doctor Coggeshall also is Professor of Medicine and a trustee of the University of Chicago, and former president of the American Association of Medical Colleges and the American Cancer Society.

The Pharmaceutical Manufacturers Association established the Commission in July in an attempt to broaden scientific knowledge regarding predictability of action in humans of the potent drugs likely to emerge in the future. The appointment of Doctor Coggeshall was made by Eugene N. Beesley, chairman of the PMA board of directors and president of Eli Lilly & Company.

Doctor Coggeshall has served as chairman of the Research and Development Committee for Medical Research for the Department of Defense and as special assistant to the Secretary of Health, Education and Welfare. He was special advisor to the military services during World War II and has received numerous awards for his contributions to medicine.

PG Course in Georgia

The Department of Continuing Education at the Medical College of Georgia will sponsor a postgraduate course on "Clinical Pathology in Medical Practice" in Augusta, October 23-25. Further information may be obtained by writing Dr. Claude-Starr Wright, Director, Medical College of Georgia, Augusta, Georgia.

Congress on Mental Illness In Chicago, Oct. 4-6

The First National Congress on Mental Illness and Health will be held in Chicago, October 4-6. The purpose of the Congress, held with the cooperation of the American Psychiatric Association and the support of the National Association for Mental Health, is to implement the broad new mental health program developed by the AMA Council on Mental Health.

The program represents several years of study and discussion and draws heavily upon such sources as action for mental health, the AMA's preliminary conference on mental illness and health and meetings with the chairmen of the AMA's state committees on mental health.

Three days of the Congress will be devoted to planning specific activities implementing the AMA program. There will be no formal presentation of papers and participants will meet in discussion groups to develop coordinated and continuing mental health programs to be carried out at the national, state and local levels.

Further information concerning the meeting may be obtained by writing the AMA Council on Mental Health, 535 N. Dearborn Street, Chicago 10, Illinois.

W. Va. Diabetes Association To Meet In Morgantown on Sept. 22

The West Virginia Diabetes Association will hold its annual meeting at the West Virginia University School of Medicine in Morgantown on September 22.

The following scientific program will be presented in connection with the one-day meeting:

"Diabetic Myelopathy."—John Jones, M. D., and John Nelson, M. D., Department of Medicine, West Virginia University School of Medicine.

"Clinical Classification of Diabetes as the First Step in Therapy."—Thaddeus Danowski, M. D., Department of Medicine, University of Pittsburgh School of Medicine, Pittsburgh.

"Insulin Resistance and Antagonism: And Potential Clinical Significance."—William G. duM. Gwinup, M. D., Department of Medicine, Ohio State University College of Medicine, Columbus.

Dr. Thomas H. McGavack of Martinsburg, the president, will serve as chairman of the meeting. Other officers are Drs. Richard V. Lynch, Jr., of Clarksburg, president elect; Lyle D. Vincent of Parkersburg, vice president; and William C. Revercomb, Jr., of Charleston, secretary-treasurer.

ACCP Meeting in Philadelphia

The American College of Chest Physicians will sponsor a postgraduate course on "Recent Advances in the Diagnosis and Treatment of Disease of the Heart and Lung" at the Warwick Hotel in Philadelphia, September 17-21.

The registration fee will be $75 for members and $100 for non-members. Further information may be obtained by writing the American College of Chest Physicians, 112 E. Chestnut Street, Chicago 11, Illinois.

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Research in the Service of Medicine

WVU Medical Center
—News—

DEAN Clark K. Sleeth announced that 60 students have been accepted as members of the first-year class at the West Virginia University School of Medicine. Fifty-two members of the new class are residents of West Virginia.

A husband-wife team and seven women are among those who have been accepted and will begin their studies this month. The first class of 15 physicians received M. D. degrees last June. Continuing toward completion of their four-year curriculum this fall will be 48 senior medical students, 40 juniors and 60 sophomores.

Mr. and Mrs. H. Alexander Wanger of Shepherdstown represent the first husband and wife combination to start medical school together at the University. Both Mr. Wanger's mother and father are practicing physicians at Shepherdstown. They are Drs. Halvard Wanger and S. Elizabeth McFetridge.

Members of the new class, their home towns and undergraduate institution follow:

Beckley—John B. Dorsey, WVU.

Charles Town—Robert L. Lorenzo, WVU.

Charleston—Sanford B. Diznoff, Eleanor M. Hyde, James R. Young, all WVU; Paul E. Lanham, University of Virginia.

Clarksburg—James F. Carney, Jackie L. Summers, both WVU; Ethel L. Eschenmann, Alderson-Broaddus.

Fairmont—Robert S. Salisbury and Arthur N. Ward, both Fairmont State College; Frederick Neil Stimmill and John M. Vacher, both WVU.

Follansbee—William Renforth, WVU.

Gassaway—John E. Beane, WVU.

Grafton—Charles E. Haislip, WVU.

Grantsville—William E. Barnes, Glenville State College.

Holden—Clayton E. Linkous, Jr., Virginia Polytechnical Institute.

Huntington—William E. Christian, Jr., and Marian L. Upchurch, both Marshall University; William A. Neal, Xavier University.

Keyser—Michael W. Montgomery, Potomac State College; Randolph L. Pifer, WVU.

Kimball—Tony C. Majestro, WVU.

Kingwood—Larry T. Schwab, WVU.

Logan—Paul M. Chikos, Jr., Bethany College.

Masontown—Patsy B. Cipolloni, Jr., WVU.

Mathias—Phillip B. Mathias, WVU.

Milton—Harry E. Davis, II, WVU

Morgantown—John H. Ellyson, Mrs. Patricia M. Gregg, Lawrence A. Krames, Ronald K. Stupar, and Arthur A. Trowbridge, Jr., all WVU.

Petersburg—Phillip M. Park, WVU.

Philippi—James W. Woodford, Alderson-Broaddus College.

Princeton—Charles H. Mann, WVU.

• **Compiled from moteriol furnished by Howord Lewis, Administrotive Assistont to the Vice President, West Virginia University Medical Center, Morgontown, West Virginio.**

Ranger, Lincoln County—Gary C. Craft, Marshall University.

St. Albans—James M. Brantley, David Lipscomb College.

Shepherdstown—H. Alexander Wanger and Mrs. Nancy S. Wanger, both Shepherd College.

Sissonville—Paul Brooks, West Virginia State College.

Sistersville—Elliott L. Thrasher, Marietta College.

Skelton—Miss Ferrell Jo Pauletto, WVU.

South Charleston—Samuel L. Henson, Morris Harvey College.

Summersville—Samuel A. Strickland, WVU.

Welch—John A. Cardea, WVU.

Weston—Michael D. Butcher, WVU.

Wharton—Thomas R. Cooley, Belmont College.

Wheeling—Thomas C. Amend, Franklin & Marshall College; Maritsa P. Cosmides, WVU; Charles E. Ross, University of Pittsburgh.

Out-of-State Residents

Donald D. Glass, Uniontown, Pennsylvania, Johnstown College of the University of Pittsburgh; Joseph R. Vilseck, Uniontown, Pennsylvania, WVU; Howard Ostfield, Pittsburgh, University of Pittsburgh; Joseph J. Schwerha, Venetia, Pennsylvania, University of Michigan; Robert N. Slotkin, Lancaster, Pennsylvania, University of Pittsburgh; Barry Selmanowitz, Bronx, New York, City College of New York; Jerome A. Goldfein, Cleveland, Ohio, Ohio State University, and Robert G. Lesnock, Washington, Pennsylvania, Washington & Jefferson College.

Hospital Receives Accreditation

The University Hospital has received full, three-year accreditation by the Joint Commission on Accreditation of Hospitals. Plans also have been completed for the opening of another 50 beds in October, bringing to 300 the number commissioned in the 520-bed facility.

Dr. Charles H. Morhouse, field representative of the joint commission, inspected the WVU Hospital last June 18. This marked the first time a national official had checked administration of the hospital.

Accreditation is a mark of approval from four national medical groups—the American College of Physicians, the American College of Surgeons, the American Hospital Association and the American Medical Association.

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Dosage: Gastric hyperacidity—from 2 to 4 tablets as needed. Peptic ulcer or gastritis—from 2 to 4 tablets every two to four hours. *How Supplied:* Bottles of 50, 100, 200 and 1000.

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*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961

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The Month in Washington

• From the Washington Office of the American Medical Association.

REPORTS of possible serious side effects of three drugs led to studies and investigations by the drug industry, the American Medical Association and the Federal government. Most attention was given to thalidomide, a non-barbiturate which produces sleep without a "hangover." Births of malformed babies, mostly in foreign countries, by mothers who took the drug during pregnancy were widely reported.

The Pharmaceutical Manufacturers Association established a special drug safety group to broaden scientific knowledge regarding predictability of the effect of potent drugs on humans.

Tightening of Controls

The AMA started a special study of thalidomide. A Senate subcommittee opened an investigation. One of the first official acts of the new secretary of Health, Education and Welfare, Anthony J. Celebrezze, was to order a tightening of FDA controls over drug testing.

Thalidomide was first marketed in West Germany about five years ago. It was consumed widely in West Germany, Great Britain, Australia, Portugal and Canada. One of its uses was as an antidote for the morning sickness of early pregnancy. No significant side effects, either proved or suspected, were reported until 1961.

The parent company of Wm. S. Merrell Co. of Cincinnati, Ohio, obtained in 1959 the North American marketing rights for the drug. Merrell conducted laboratory and mass clinical tests, put the drug on the market in Canada and in September, 1961, applied for FDA approval for U. S. sales.

Dr. Frances O. Kelsey, a newly employed medical officer at FDA, moved cautiously on the application and withheld approval. In February, 1961, she read a letter in the *British Medical Journal* suggesting that thalidomide might be causing peripheral neuritis.

For withholding FDA approval of the drug, Doctor Kelsey was awarded the Distinguished Federal Civilian Service Medal by President Kennedy. The President at the same time renewed his request to Congress that it approve the Administration's drug legislation.

First reports linking thalidomide with birth malformations reached Merrell from the German drug manufacturer in November, 1961, after a German scientist reported such indications at a medical meeting. Merrell promptly sent a warning to Canadian doctors and the approximately 1200 American doctors conducting clinical tests with it. It was requested that the drug not be given to women of child-bearing age. Merrell so advised the FDA at the time also. In early March, 1962, Merrell withdrew the drug from the Canadian market and experimental use in this country, and dropped its FDA application.

Commission on Drug Safety

The PMA announced establishment and financing of a Commission on Drug Safety to, among other activities, "investigate an unpredictable problem which is assumed to be connected with use of the European drug (thalidomide)." Lowell T. Coggeshall, M. D., a leading U. S. scientist and vice president of the University of Chicago, was named chairman of the commission. He formerly was president of the American Association of Medical Colleges and of the American Cancer Society.

"The basic purpose of our commission is to study the broad and complex problems of making available to the public, with adequate safeguards for both the doctor and the patient, the therapeutic advances which will result from the enormous programs and rapid pace of medical research," Doctor Coggeshall said.

"However promising new agents may be in the laboratory, no amount of laboratory experimentation and testing can provide complete assurance of effectiveness or safety when a new drug is administered to a human being. We must attempt to reduce danger to the lowest possible degree without discouraging the imaginative research from which flows mankind's increasing release from disease."

The AMA Council on Drugs began a comprehensive analysis of the effect of thalidomide on unborn infants. In a statement, the council said:

"The AMA has been concerned about the reports of distinctive congenital malformations occurring in the offspring of patients receiving thalidomide in early pregnancy . . .

"It has been under clinical evaluation here since 1956. There have been no published reports in scientific journals of such malformations developing in connection with these trials in the United States.

"On the evidence which has been presented, it would appear that the increased incidence of extromelia in Germany, Great Britain and Australia may be related to the use of thalidomide during the early weeks of pregnancy.

"A careful analysis of the whole problem is needed. This has not yet been done and the Council on Drugs proposes to undertake a comprehensive analysis. Through such studies, it is hoped that further knowledge will be gained on the problem of congenital malformations and appropriate measures will be determined to safeguard our population."

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Obituaries

L. M. HALLORAN, M. D.

Dr. L. M. Halloran of Beckley, 58, died on July 31 at a hospital in that city.

Doctor Halloran, a native of Hinton, had practiced in Beckley since 1930. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree from the Medical College of Virginia in 1929. He served his internship and residency at St. Joseph's Hospital in Reading, Pennsylvania.

He was a member of the American College of Surgeons and the Southeastern Surgical Congress. Doctor Halloran also was a member and past president and secretary-treasurer of the Raleigh County Medical Society, and a member of the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he also is survived by three sons, L. Gregg Halloran and Randolph M. Halloran, both students at the Medical College of Virginia, and Philip B. Halloran, a student at Georgia Tech; two sisters, Mrs. L. A. Johnson of Hinton, and Mrs. R. G. Broaddus of Beckley; and three brothers, Dr. R. O. Halloran of Charleston, Percy Halloran of Talcott, and Earl T. Halloran of Hinton.

* * * *

FRED J. POTTER, M. D.

Dr. Fred J. Potter, 66, of Parkersburg, died on July 10 at a hospital in that city.

A native of Walkden, England, Doctor Potter had practiced radiology in Parkersburg since 1940. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree from the Emory University School of Medicine in 1938.

He interned at Charleston General Hospital, 1938-39, and served a residency at Cook County Hospital in Chicago. He also had postgraduate training at Memorial Hospital in New York City. He served with the United States Army during World War I.

He was a member of the Parkersburg Academy of Medicine, West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by a brother, John William Potter of Detroit, and a sister, Mrs. Owen M. Strickler of Shenandoah, Virginia.

* * * *

S. W. TRETHEWAY, M. D.

Dr. S. W. Tretheway, 70, of Wheeling, died at his home at Bethlehem, Ohio County, on July 20.

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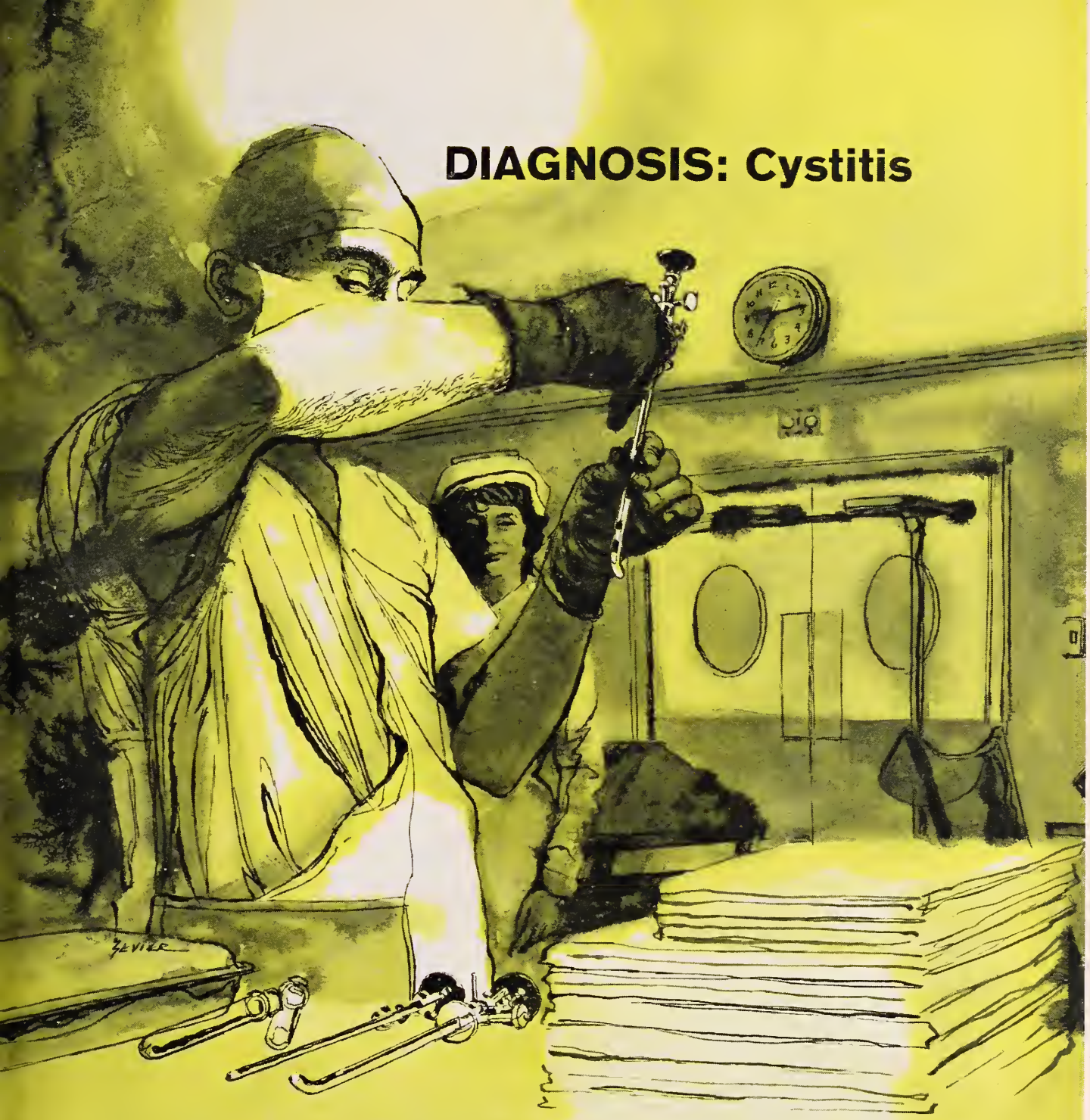

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A native of Parsons, Pennsylvania, Doctor Tretheway received his M. D. degree from the University of Pennsylvania School of Medicine in 1917.

He served as a Lieutenant in the Medical Corps of the United States Navy during World War I. On his separation from the service, he opened his practice in Wheeling.

Doctor Tretheway was a former member and past president of the Ohio County Medical Society, and a former member of the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he also is survived by two sisters, Mrs. Charles Stewart and Mrs. Sam Temby, and a brother, William Tretheway, all of Forty Fork, Pennsylvania.

* * * *

ROBERT S. WIDMEYER, M. D.

Dr. Robert S. Widmeyer, 62, of Parkersburg, died on July 19 at a hospital in that city after suffering a heart attack earlier that day at his home.

A native of Martinsburg, Doctor Widmeyer had practiced in Parkersburg since 1928. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree in 1925 from the University of Maryland School of Medicine.

He served his internship at a Parkersburg hospital and practiced in Baltimore before returning to Parkersburg in 1928.

During World War II, Doctor Widmeyer served in the Medical Corps of the United States Navy. He was separated from service in 1945 with the rank of Captain.

He was a member of the American College of Surgeons and the Southeastern Surgical Congress. He also was a member of the Parkersburg Academy of Medicine, West Virginia State Medical Association and the American Medical Association.

Besides his widow, he also is survived by two sons, Robert S. Widmeyer II, a student at the University of Maryland; Stephan B. Widmeyer of Parkersburg; a daughter, Susan Widmeyer of Parkersburg; and two sisters, Mrs. Boyd Russler of New Castle, Pennsylvania; and Mrs. Grace Tomson of Martinsburg.

Pfizer Establishes Scholarship Program

Each school of medicine in the United States will be provided with a $1,000 scholarship beginning with the 1963 academic year under a new program established by Pfizer Laboratories, a division of Charles Pfizer & Company, Inc.

The firm said the scholarships will be administered solely by the dean of each medical school or by a committee established by him. The scholarships are designed primarily to apply toward academic and subsistence expenses of one student.

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1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

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County Societies

CENTRAL WEST VIRGINIA

The regular monthly meeting of the Central West Virginia Medical Society was held at the First Methodist Church in Richwood on July 12.

Dr. J. E. Echols of Richwood was chairman of the program which included golf at the Cherry Hill Country Club, "Open House" at the home of Doctor and Mrs. Echols and the annual dinner at the church.

Walter T. Judy, Vice President and Trust Officer of the Kanawha Banking and Trust Company in Charleston, delivered an address on estate planning.

From Test Tube to Bedside

Each year the pharmaceutical industry in this country makes, discovers or synthesizes more than 100,000 chemical compounds or substances. Of these perhaps about 2500 to 2800 may reach the stage of investigation to determine their usefulness in humans. And of this latter number perhaps 30 to 40 may eventually appear on the market.

Incidentally, to undertake this huge job of searching and testing there are more than 16,000 scientific personnel employed by the pharmaceutical industry. And about 5 to 6 years, as an average, intervene from the time an idea is discovered in a test-tube and when it finally emerges for general use in sick people.—Austin Smith, M. D., in Military Medicine.

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Many physicians frequently complain that hospital records involve too much "red tape." The correct preparation of histories, physical examination records, operative reports, progress notes, and order sheets—all have created work for the busy practitioner of medicine. Service on tissue and medical record committees are burdens. Work on credentials and executive committees can be frustrating and time consuming. Realization that this is all done on a voluntary basis tends to add impetus for throwing the system out the window!

Nevertheless, this is exactly as it should be, whether the hospital concerned is small or large. Without the physician's full cooperation, the institution not only cannot function properly; it cannot function at all and its patients receive inferior medical care.

The simple expedient of recording an accurate and full history and physical examination immediately establishes that a physician is practicing a good type of medicine. Complete, up-to-date progress notes signify that the physician is doing all that he can to further the patient's progress while he is in the hospital. Proper description of an operative procedure assures not only a legal record but a record for future use.

A properly functioning tissue committee assures surgeons not only that they are correct in the preoperative diagnoses but also that they are doing the types of surgery that are most beneficial to their patients. Service by qualified physicians on a credentials committee is a safeguard to one's colleagues, hospital, and patients that the right men (and women) are at the "helm." Finally, adequate time devoted to work of the executive committee will assure the proper liaison between the many ancillary departments of the hospital, providing comprehensive medical care for patients. —Harvey Renger, M. D., in Texas State Journal of Medicine.

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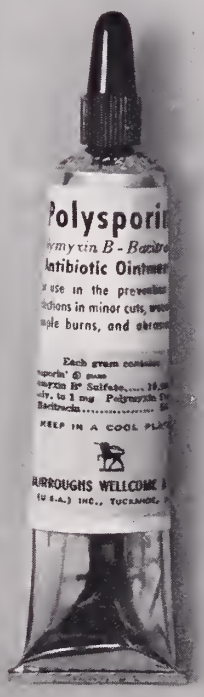
Poor Quality of Russian Drugs

Every year there is an increase in the production of various drugs in our country. Many of them are sent for evaluation testing to the Central Pharmacological Research Institute. In the last year, for example, 112 various drugs were sent to us—ampules, tablets and others. And, it is deplorable that 75 per cent of them did not meet the requirements of the official governmental pharmacopoeia and the technical standards. In the first three months of the current year, the Institute received some dozens more of pharmaceuticals and this time again, from the 74 tested, 58 did not meet the requirements.—Meditsinskii Rabotnik (Moscow).



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Book Reviews

DR. MARY WALKER: THE LITTLE LADY IN PANTS—By Charles McCool Snyder. Pp. 166, with pictures. Vantage Press, Inc., 120 West 31st Street, New York, New York. 1962. Price $3.95.

Mary Edwards Walker was born on a farm near Oswego, New York, on November 26, 1832. She was well educated and decided to become a medical missionary mainly because of the large number of medical schools in the United States. She obtained admission to the Syracuse Medical College and was graduated in June 1855. Shortly afterward she married Dr. Albert Miller, one of her classmates in medical school. At this time she had adopted the bloomer fad, with a tunic or coat dress reaching below the knees. At the marriage ceremony she omitted the word "obey" and was dressed in trousers and dress coat.

This unorthodoxy identified her as a militant feminist and closed many doors to her, including her new husband, for her wedded bliss ended suddenly when she discovered that Albert was unfaithful. They separated in September, 1859. She continued her medical practice and became greatly interested in women's dress reform.

At the outbreak of the Civil War she volunteered her services at the makeshift hospital set up in the United States Patent Office in Washington. She invented her blue officer uniform, pants with gold stripes, a felt hat encircled by a golden cord and the green sash of a surgeon. She was authorized to accompany wounded soldiers and was attached to the Sanitation Commission. Her duties consisted chiefly of those of nursing and she served the wounded after the Battle of Fredericksburg, on the Tennessee front and at Chickamauga in September, 1863. In April, 1864 she was captured by the Rebels and was confined in a political prison called Castle Thunder in Richmond, Virginia; she was released in August, 1864 and returned to her former duties in Washington.

Finally on October 5, 1864 she was awarded a contract as Acting (female) Assistant Surgeon, United States Army, with a salary of $100.00 a month and assigned to the Women's Prison Hospital in Louisville, Kentucky. On January 24, 1866, she received from President Johnson the Congressional Medal of Honor for Meritorious Service dated November 11, 1865.

After the war Doctor Walker continued her unusual costume, usually a black broadcloth suit coat, short skirt and pantaloons. She practiced medicine and engaged in practically any and all controversial matters including dress reform, woman's suffrage, tobacco and alcohol evils, sexual morality, Democratic politics in New York State, etc. Her antics continued in Washington in 1883 while employed in the Pension Division of the Department of Interior, finally ending in her dismissal after a year of controversy.

Doctor Walker's declining years were spent on her farm near Oswego, New York, where she died February 21, 1919 at the age of eighty-six.

This is an excellent depiction of the status of medical practice immediately prior to the Civil War and ex-

plains the ample supply of young doctors throughout the (then 34) United States resulting from a plethora of medical schools of all grades and quality.

The military services of both North and South were serviced by doctors who received their diplomas from Allopathic, Homeopathic and Eclectic method medical schools which flourished in great numbers throughout the country.

The adventures of Doctor Walker before, during and after the Civil War seem rather novel and there is never a dull moment in her life. Her experience during the war in 1863 reads like a cloak-and-dagger thriller. Altogether, this is a very interesting biography well illustrated with contemporary photography including the rather novel military uniform which Doctor Walker used during the Civil War.—Howard G. Weiler, M. D.

* * * *

PHYSICAL DIAGNOSIS—By Ralph H. Major, M. D., Professor of Medicine and of the History of Medicine, The University of Kansas; and Mahlon H. Delp, M. D., Professor of Medicine, The University of Kansas. Pp. 355, with illustrations. W. B. Saunders Company: Philadelphia and London. Sixth Edition. 1962. Price $7.50.

This is the latest edition of a work begun in 1937. It has always kept in date with the advances in physical diagnosis, and those who are familiar with the book should be informed that this is a completely rewritten edition.

The introduction is a delightful piece of informative historical writing that is a welcome relief from the usual type of medical literature. Each chapter has an historical review with many illustrations that develop interest in the following discussion.

The book is concerned with the use of the examinee's physical senses and revives a flagging interest in the art of physical examination. The book has 16 chapters covering the entire body. There is nothing concerning laboratory nor x-ray studies.

This book will be helpful in diagnosis. Even a rapid review will remind the physician of forgotten teaching and he will learn a few new tricks in every chapter.

It will encourage the physician to give more time to examination and eliminate some unnecessary laboratory and x-ray studies. In this day of assembly line medicine, some renaissance in physical diagnosis will prove exciting to students and physicians who wish to develop their diagnostic competence.

The book is highly recommended to all students and practitioners.

Hospital Association Meeting

More than 15,000 persons are expected to attend the 64th Annual Meeting of the American Hospital Association which will be held at McCormick Place in Chicago, September 17-20.

In addition to the general assemblies, nine program sessions, dealing with specific phases of hospital operation, will be held each morning and afternoon during the meeting. Nearly 500 exhibits will be on display.

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OCTOBER
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Vol. 58 No. 10

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 346-0551.

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References: (1) Katz, Y. J., & Bourdo, S. R.: *Pediat. Clin. North America* **8**:1259, 1961. (2) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Whitaker, L.: *Canad. M. A. J.* **84**:1022, 1961. (6) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959.

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The West Virginia Medical Journal

October, 1962 Vol. 58, No. 10

Medical Freedom—A Heritage We Must Preserve*

D. E. Greeneltch, M. D.

Without question the past twelve months, since our last meeting here at The Greenbrier, have been crucial times in our efforts to maintain a system of free medical practice. What with crises in our West Virginia Medical Care for the Aged program, continued efforts by the Administration in Washington to establish that first step toward socialized medicine, cooperation with numerous state and national committees working toward improvements in medical care for specific diseases, mental health, youth fitness, medical careers recruitment, improved distribution of physicians, voluntary insurance programs and the consideration of the many other facets of our changing environment, we have all been kept busy above and beyond those efforts normally expended in conducting our everyday practice.

We are happy to participate in all these varied programs if by so doing we can assure a more healthful nation. But by this cooperation I hope we are not helping to create a dependency syndrome, common to the welfare state, which is productive of nothing and is highly contagious.

A demand for social and economic security not related to labor and productivity, but as an inalienable right, is not realistic. While a basic degree of security is desirable and healthful, the soporific effort of total security, by its very nature smothers initiative, begets mediocrity, threatens liberty and could destroy our nation as we know it today.

"Cradle to Grave" protection by the Federal government is not the answer to all our problems. It is not the method by which our country became great nor is it the way in which its strength will be preserved. Our people must realize that the Federal government is not a source of power or an inexhaustible fountain of largess. As citizens we must assert ourselves toward directing our own destinies rather than to be content with allowing the government to decide our future and how to give back to us our own money in a planned economy. An enlightened society is obligated to help those who cannot help themselves but to do more is to weaken the moral fiber of our nation. When the Federal government tries to take over all the responsibilities of individuals, able and willing to care for themselves, it is exceeding its prerogatives.

It would seem that present problems concerning medical care pertain more to its rapidly increasing cost and complexity than to the question of the availability of medical service. Although it is often inferred that medical care is not now provided for all those who need it, this is just not true. It has long been a matter of pride to the medical profession that it, with the support of the community, has seen to it that everybody receives basic medical coverage, regardless of their ability to pay and that the standards of this care are higher than anywhere in the world.

It is evident that the providers of medical care cannot be limited to doctors, nurses, technicians, health departments and social welfare agencies.

The Author

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*Annual Address of the President, West Virginia State Medical Association, 95th Annual Meeting, The Greenbrier, White Sulphur Springs, August 22, 1962.

These groups do not provide the funds. The providers must therefore also include those responsible for financing of this care, which in any system for medical care is ultimately the consumer, or the public. Every person must meet these costs either out of his pocket, through prepayment insurance or directly or indirectly through taxes.

Propaganda freely spread by advocates of the welfare state has led to curiously unclear thinking on the part of some of our citizens. It is believed by many that medical care should be free. The fallacy here is obvious. It must ultimately be paid for by the consumer, the patient. The more complex the system of providing care, the more costly it becomes, because the cost of the system must be added to the cost of the care. Quality medical care is expensive, yes, but it would not become less so under a Federal system. It could, however, easily assume a state of mediocrity under the inflexibility inherent to governmental administration which would make this care infinitely less desirable and beneficial to those it would serve.

Essentials of Good Medical Care

Just what are the essentials of this medical care which Americans must provide for themselves? A report by the American Medical Association provides an answer: "Medical care is that service which uses every means available to secure and maintain a state of physical well-being in the individual. Good quality medical care results from the full use by the physician of his art, skill and knowledge and his utilization of the scientific facilities available to him. It depends upon the physician's sincere interest in the patient and the patient's faith in the physician."

The patients' special and particular needs for medical care must be recognized, diagnosed and treated by a doctor whose primary interest is the health and welfare of the individual patient. Somehow these essentials of the best medical care must remain realities in our new technological, economic and social environment.

I am not worried about the abilities of the medical profession to consider and successfully surmount the varied challenges which confront us at this time relative to providing the same high quality medicine we have become accustomed to in this country. Our problem at this time is that of deterring the social planners in Washington from influencing our citizens and through them our Congress to take precipitous action relative to the provision of medical services. Medical care can only be provided by physicians and I am sure the method by which these services become available should evolve from the same source.

The Initial Step

Regardless of statements to the contrary, we all know that the Administration's efforts to establish a compulsory hospital-nursing home program under social security for our senior citizens, regardless of need, is but an initial step toward complete socialization of medicine. President Kennedy in his Madison Square Garden speech of May 20 stated his program was just a "start." This statement, like former Representative Forand's "foot in the door," and Walter Reuther's "initial piece of legislation," clearly indicates the adoption of such a program would be just a beginning. Witness Saskatchewan's progress from a compulsory hospital plan in 1947 to the complete socialization of medicine in 1962.

In a message to the Congress on February 27, 1962, President Kennedy made the following statement: "Basically health care is a responsibility of individuals and families, of communities and voluntary agencies, of local and state governments but the Federal government shares this responsibility by providing leadership, guidance and support in areas of national concern."

We agree with this statement and its was on such a premise that the Kerr-Mills Law was passed in September 1960 and implemented in West Virginia less than a month later. This liberal grant-in-aid legislation was designed to provide a full spectrum of medical care, not just hospitalization, for those over 65 who, though not indigent, were of modest income and resources. This was in keeping with Mr. Kennedy's above statement concerning the chain of responsibility. I do not believe, however, that people able to provide for themselves can be considered problems of national concern, nor should they be. These individuals would come under the first sentence of Mr. Kennedy's statement; i. e., "Basically health care is the responsibility of individuals."

Without doubt the Administration's introduction and support of HR 4222, before the Kerr-Mills program could even get started, influenced some state legislatures to defer implementation of the MAA provisions of this law and others to inadequately finance their programs. Certainly the Department of Health, Education and Welfare was less than enthusiastic in its cooperation and many state officials left much to be desired in their administration of this program. The fact that the Kerr-Mills Law has made such great progress in view of such powerful opposition speaks well for the soundness of this legislation.

Live Political Issue

We cannot assume because we have succeeded in containing the President's medical care program during the current sessions of the 87th Congress that it will forever remain dormant. Far from it. Our President has assured us that medical care for the aged under social security will be a very live political issue in the November election. Therefore the present armistice is not the time for a well earned rest but instead offers an opportunity to redouble our efforts to come up with sound solutions to any problems that might exist relative to the issue that has been chosen for us. A problem exists, real or imaginary, when sufficient people think it so. There has been a definite swing away from the Administration's program as our citizens have become cognizant of the real issues involved. We must continue to spread the truth since the battle will be fought again next year in the halls of Congress with those elected this November participating in the campaign.

Physicians have traditionally avoided active political participation. Now the necessity of becoming politically active has been thrust upon us. It is necessary, purely as a matter of survival, that we express ourselves and exercise the latent political influence which, even though unused, has always been recognized and respected by political office holders.

The extent of this latent power can be glimpsed when it is realized that the physicians of this country see each day two million patients. Not every patient can be swayed or influenced in his political opinions but in spite of what public opinion polls and public relations counselors have to say about the deteriorating image of the American doctor, the relationship between the individual patient and his individual doctor is still a sound one based on trust and respect. We as a group and as individuals are convinced that currently proposed political schemes for health care are unsound and will be ultimately detrimental to the welfare of our patients. We can speak with conviction and sincerity on this subject. We have not only the right but the duty to speak.

Our Responsibilities as Physicians

It is in our daily contacts with patients that we can most effectively work to maintain what is in our opinion and in the opinion of the world the finest system of medicine ever known to man. Individual doctors talking to individual patients about the political aspects of proposed medical care legislation and about the candidates who propose and support objectionable legislation is the first and most effective political action that we, as physicians, can engage in.

Secondly, we should endorse and support group efforts beginning at county society levels and extending through our state association to the national AMA. During the past year there has been unprecedented support and cooperation in a common cause at all of these levels.

Thirdly, we must all take a direct interest in, and engage actively in the organization and planning of the political party of our choice. We must contribute financially to candidates of our choice. We should encourage any doctor with the inclination or interest to run for a local, state, or even national office.

In summary, it appears that the practice of medicine has been thrust irrevocably into the political picture. We must accept this as a fact of life. To aid the survival of medicine as we now know it, like it, and as we have helped to build it, we must exert our influence through our patients, through our professional organizations, through organized political action groups, and through our own political parties.

Preserving Medical Freedom

Finally, let us remember that medicine is not going to survive as an isolated example of free enterprise. Whether or not we completely agree with all of the issues involved, the survival and the future of medicine as we would have it is bound to the politically conservative group in both parties. Fortunately, there are strong conservative forces in both major parties. We dare not deny our support to these groups through the whole spectrum of political issues. During the past year a major battle has been won—but the war is not yet over and it is not likely to be for a long time to come. We must join with other clear thinking individuals and groups in this fight to preserve medical freedom in the face of powerful and resolute enemies.

Norethynodrel as an Oral Contraceptive: Experience in Private Practice*

Charles S. Mahan, M. D.

During the past eight years extensive laboratory and clinical studies have been made in the search for a satisfactory oral contraceptive.[1] The substance must be effective and harmless, and must have patient acceptability. Among more than two hundred compounds tested, protesterone derivatives of the 19-norsteroid group have been found to fulfill most closely the requirements of an ideal oral contraceptive.[2] Of these, norethynodrel has received widest attention. Norethynodrel in combination with ethinyl estradiol 3-methyl ether has been marketed (Enovid) and has been used extensively in clinical practice.

The mode of action of the drug probably is to inhibit the release of gonadotrophic hormones from the pituitary and consequently prevent ovulation. The drug must be taken assiduously for twenty days, from the fifth day of the menstrual cycle to the twenty-fourth day. Aberrations in dosage and irregularity of administration may render its purpose as a contraceptive ineffective. In the original reports the dose administered was 10 mg. daily. More recent studies demonstrate that a dose of 5 mg. daily is effective in preventing ovulation and has a tendency to produce a lesser number of side effects. With the smaller dose, however, the possibility of escape bleeding is enhanced.

Material and Methods

The patients observed in the present study were selected from the private practice of the author and were carefully screened from among those seeking contraceptive advice during the year 1961. The first hundred women deemed suitable for oral contraception are included in the study.

The patients were screened as to strength of motivation in desiring oral contraception. Patients not strongly motivated were advised to use other methods since adherence to the prescribed course of therapy is essential to its success.

Each patient's complete history was recorded and each was given a general physical examination and a pelvic examination before being considered for the group. Those thirty years of age or older had a cervical cytological smear. Patients who had successfully used other methods of contraception, particularly diaphragm and jelly, were discouraged from changing methods. Women selected for the use of norethynodrel were given detailed instructions. They were advised that the drug may be continued cyclically for one to two years with periodic examinations.

The hundred women observed ranged in age from 19 to 42 years, and had been taking norethynodrel for periods of from four to twelve months, representing treatment of more than 800 menstrual cycles.

Results

In the 800 cycles treated there were no known pregnancies. There were no cases in which the drug had to be discontinued because of intolerance. There were minor side effects in approximately 10 per cent of cases. They were controlled within one to three months by symptomatic treatment and in some instances by adjustment of dosage.

Discussion of Side Effects

The introduction of a Pro-Banthine with Dartal tablet to be taken with the first three doses of norethynodrel for the first two months practically eliminated the problem of nausea. In the cases in which nausea persisted in spite of the medication, the difficulty was eliminated when the drug was taken after the evening meal instead of at bedtime.

Three patients experienced severe breast engorgement during the first month of medication. Two of these continued to have considerable engorgement for three months at the end of which time the condition disappeared.

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*Presented before an Obstetrical-Gynecological Conference, sponsored by the Department of Obstetrics and Gynecology, West Virginia University School of Medicine.

Submitted to the Publication Committee, March 23, 1962.

Abdominal distention occurred in three cases with disappearance by the third month of medication without any specific treatment.

Weight gain is a problem associated with this medication, due to fluid retention frequently characteristic of steroid therapy. With the institution of salt restriction and a high protein diet, the weight in such cases returned to normal within four months.

Infrequently, headache occurred about midway in the monthly medication regimen. Relief was obtained by routine methods.

Three patients experienced rather severe cramps and pelvic pain during the first month of medication, but these annoying symptoms disappeared after the third month.

Some investigators have reported an increased libido in patients taking norethynodrel. This probably is due to the establishment of confidence that conception is unlikely, rather than to any specific action of the drug.

Only two patients experienced vertigo and in both instances it was accompanied by mild headache. It was believed that this symptom was of little significance.

IDIOSYNCRACIES—PER CENT OF CASES

Side Effects	*1st mo.*	*2nd mo.*	*3rd mo.*	*4th mo.*
Nausea	2	2	0	0
Mastalgia	3	2	2	0
Weight gain	6	4	2	0
Headache	2	0	0	0
Cramps	3	2	1	0
Vertigo	2	1	0	0
Vaginal bleeding	20	8	0	0
Abd. distention	3	2	0	0

Vaginal bleeding or spotting was the most common undesirable side effect noted in the series and probably was due to the fact that in 90 per cent of cases the 5 mg. dose was employed. The complication was eliminated by increasing the dose to 10 mg. for 4 days. The original 5 mg. dose was then resumed for the remainder of the treatment without difficulty. In some cases spotting was due to omission of a dose of medication. Frank bleeding occurred in six cases during the first month of therapy. In these, the dose was increased to 10 mg. for the remainder of the month, resulting in elimination of the disorder by the third month.

Patients who had irregular menses experienced regular cycles while taking norethynodrel. Many who had suffered from menstrual disorders found that they had been corrected. Individuals who previously had suffered from severe primary dysmenorrhea have enjoyed complete relief while taking the medication.

In 4 cases menstrual bleeding failed to occur following the first month of therapy. In 3 cases, the patients missed periods after having been on the drug for varying periods of time. In all instances norethynodrel was started seven days after completing the previous course and resulted in a menstrual period the next month.

Patients with the history of a twenty-one day cycle are early ovulators and these were advised to abstain from coitus until the first few doses of norethynodrel had been taken. After the first month there probably is no danger of pregnancy.

Postpartum mothers were advised to wait until two menstrual periods had occurred before starting the medication. The drug was not given to nursing mothers because of the possibility of interference with lactation.

Ideal Use of Oral Contraceptive

The ideal use of the oral contraceptive is in early marriage. In this group the highest patient acceptance and the least number of side effects occurred.

There is a return to normal menses after the drug is discontinued and, in many instances, an improved cyclic pattern is maintained.

Six patients who had had extensive acne since puberty experienced marked improvement of the previously infected areas by the end of the third month of cyclic therapy with norethynodrel.

Summary

Results of the present study indicated that oral contraception is an effective method of birth control. In this report covering 800 menstrual cycles no pregnancies occurred. The drug must be taken in strict compliance with instructions. Side effects encountered were minimal and disappeared after two or three months. The benefits far outweigh any disadvantages noted. There was return to normal ovarian and endometrial function when the medication was discontinued. In the series of 100 cases, there was enthusiastic patient acceptance.

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The Problem of the Full Stomach*

Allen E. Yeakel, M. D.

ANESTHESIOLOGY has been described as a specialty characterized by long intervals of boredom punctuated by short periods of sheer terror. Few catastrophes are more terrifying than vomiting and aspiration and the events which follow. If you have never seen this happen, you are indeed fortunate; if you have seen this happen to the patients of others only, you are fortunate that it has not happened to your own; if it has afflicted someone in your own practice, you are fortunate if you allowed the impetus of the misfortune to drive you to master the principles of the problem. If it has occurred in your practice and you passed it off as an unavoidable accident, you are indeed unfortunate for you may well see it happen again.

To those of you who recognize the importance of the problem of stomach content in patients about to be anesthetized for obstetrical or surgical procedures, I apologize for belaboring you with authors, dates and data, but it is necessary in my effort to convince everyone present of the gravity of the problem. That the hazard of stomach content is not universally appreciated is evident from a report in the literature of up to 5 per cent of a series of over 600 cases in which the patients were deliberately allowed to eat within four hours of general anesthesia for elective procedures.[29]

Review of Literature

The hazards of anesthesia and surgery in patients with matter in their stomachs probably was first appreciated editorially by Woillez,[1] in 1872, and by Becker, in 1887.[2] Both men described bronchopneumonia as a major complication of abdominal surgery. Myerson[3] studied the problem of aspiration in 100 consecutive tonsillectomies in 1924, finding evidence of aspiration in 72 of 78 patients who did not cough during or following the procedure, in contrast to none in the 22 patients who, carried at lighter levels of anesthesia, did cough during or following surgery. Balfour and Gray,[4] in 1933, also called attention to vomiting and aspiration as an anesthetic complication. More specific comments and case reports appeared in 1940 in the writings of Hall[5] and in a report by Waters and Harris,[6] the latter noting particularly the ease and and frequency with which vomiting and aspiration occur in obstetrical cases.

*Presented before a meeting of the Monongalia County Medical Society in Morgantown on March 6, 1962.
Submitted to the Publication Committee, April 9, 1962.

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From 1946 on, results of studies of large numbers of carefully observed, well documented series of cases were made available by Mendelson,[7] Beecher,[9] Adriani,[10, 12] Hingson,[16] Hellman,[17] Cole and Corday,[18] Salvia and Steffen,[19] and many other individuals,[11, 13, 14, 28, 30, 31, 32] and study commissions.[8, 15] Mendelson was first to define the syndrome which bears his name. In 44,016 delivered patients he found that aspiration occurred in 45, or 0.15 per cent, being recognized clinically at the time of aspiration in a little over half of the cases. Liquid aspiration occurred in 40 cases; solids were aspirated in 5, with 2 deaths.

Hingson, in 1956, reviewed the world literature for the previous decade and found that of 330 reported maternal obstetrical deaths from anesthetic causes, 155, or approximately half, were caused by vomiting and aspiration. This is not too surprising in the light of Salvia's and Steffen's findings, i. e., that one-half to three-fourths of patients eating at the onset of labor and then receiving sedation retain large amounts of the food in their stomachs up to the time of delivery, be it five hours or twelve hours later.

In 1952 the British Committee of the Council on Anesthesia studied 232 anesthetic deaths and found 25 per cent directly related to regurgitation and vomiting. In the same year Beecher placed Evans Blue dye in the stomachs of patients prior to general surgery, performed bronchoscopy on completion of surgery, and found in 300 cases an overall incidence of 26.3 per cent regurgitation, 16.3 per cent for aspiration, 8 per cent frank vomiting, and 8.3 per cent silent aspiration. A similar study by Adriani, in 1954, covering 946 patients, paralelled Beecher's results,[27] with minor exceptions. Cole and Corday, in 1956, analyzed 132 cases of cardiac arrest occurring in a

two-year period in one quarter of the residency-approved hospitals in Los Angeles. Approximately 10 per cent were caused by aspiration of vomited or regurgitated material. In the same year, Edwards'[26] group, analyzing 589 anesthetic deaths, found 110 or 18.6 per cent due to this hazard.

Clinical Impression Vs. Reliable Data

I doubt that anyone unconvinced of the gravity of the problem by this data is capable of being convinced unless, perhaps, by the realization that such calamities are nearly 100 per cent preventable. The doctor who comments, "Why I have seen hundreds of women delivered under general anesthesia but never saw one aspirate," must face up to the fact that he is flirting with a preventable death. Regardless of the odds against such a death, this position is untenable. The discrepancy between clinical impression and carefully collected data is well known[20, 23] and is worthy of mention in this regard.

Other Full Stomach Suspects

In addition to the unprepared obstetrical patient, the emergency surgical patient is a prime suspect of having a full stomach. Trauma, pain, stress or emotional upset can delay emptying of the stomach twelve, twenty-four and even thirty-six hours. The question to ask is not, "How long has it been since you have eaten?" but "How long after you last ate were you hurt?" Or "How long after your last meal did you feel yourself going into labor?" The prolongation of emptying time by narcotics and other sedatives is well known.[19] Intestinal obstruction, bleeding esophageal varices, gastric lesions, or duodenal ulcer can easily result in a full stomach in the case of a patient who has been NPO for twenty-four hours. All these situations call for a high index of suspicion on the anesthesiologist's part that a full stomach may be present. Moreover, a nasogastric tube is no guarantee that all of the stomach content has been removed. The tube may not be in the stomach, or it may not have been put to suction, or it may be blocked or clamped, or the end may not rest in the most dependent portion of the gastric cavity.

Frequency Factors

Beecher's and Adriani's groups spent considerable time trying to determine what factors increased the frequency of vomiting, regurgitation and aspiration. Both groups found, for example, that a "rough" anesthetic induction doubles the likelihood, also that the presence of an endotracheal tube approximately doubles the overall incidence of aspiration, but both groups used non-cuffed tubes. Adriani, in later work,[21] found that properly employed cuffed endotracheal tubes afforded 100 per cent protection against aspiration. Advanced age, debilitation, and central nervous system depression depress the reflexes protecting the airway from aspiration.[22] The effect of patient position also has been studied, regurgitation being more likely in the right lateral or head-down position than in the left lateral or supine, but aspiration being less likely in these positions once regurgitation or vomiting has occurred.

It is a matter of common experience that vomiting is most likely to occur at the time of induction of general anesthesia. But it can occur at any time. During abdominal surgery, manipulation of or pressure on the stomach can lead to regurgitation. Abdominal distention, whatever the cause, is a temptation to the uninformed bystander to press on the belly and reflux gas plus gastric fluid into the pharynx. In the immediate postoperative period in the operating room and on the way to and in the recovery area the patient is also likely to vomit and aspirate, particularly if his airway reflexes are partially obtunded by residual general anesthesia or partially paralyzed by residual effects of muscle relaxants. It is of the utmost importance that constant vigilance be exercised and corrective measures instituted at these times. The time spent in the corridors on the way to recovery room is particularly hazardous because of the lack of instantly available suction.

Prophylaxis and Management

What, then, is the overall approach to the problem of the patient who comes to delivery or surgery with a full stomach? You are all familiar with the "NPO after midnight" which appears on every elective adult surgical patient's preoperative orders. This avoids the dilemma altogether most of the time, and is listed by Wycoff[24] as the first method of preventing aspiration in the operating suite, i. e., preventing material from entering the stomach in the first place. When the stomach is already full, however, there are other solutions, which he lists:

1. Removal of the stomach contents.
2. Prevention of the exit of stomach contents from the stomach.
3. Prevention of aspiration by use of a cuffed endotracheal tube.
4. The use of regional anesthetic techniques which are unlikely to precipitate vomiting and which leave the airway reflexes intact.

Of the four methods it is fairly evident that the last should be preferable to surgeon, patient and anesthesiologist alike. If the location or duration of surgery or the refusal of the patient to accept regional anesthesia militates against its use, the third method—use of the cuffed endotracheal tube

—is the next most preferable. Complete emptying of the stomach by suction and gavage through a wide bore stomach tube cannot be relied upon, and it takes but one piece of hamburger to spell catastrophe. Stimulation of the posterior pharynx with the finger, the use of emetics, and the use of ether vapor in high concentration to stimulate vomiting also fall short in this respect, but may have application in instances in which they are the best methods available. The cuffed endotracheal tube, as noted before, has been found to give 100 per cent protection against aspiration. It is best inserted with the patient awake. If vomiting should occur in the process, it is merely a step in the right direction. With or without careful use of topical anesthetics but always with gentleness and constant reassurance, this technique is acceptable to most patients.

When, because of the need for the ultimate in speed or because of refusal or inability of the patient to cooperate, an awake intubation is impossible, a rapid induction technique using, for example, barbituate and rapid acting muscle relaxant can be employed with the head of the table elevated (as I prefer) to prevent regurgitation, or with the head of the table lowered to prevent aspiration should regurgitation occur. In either position the presence of all necessary equipment including a powerful energized large bore suction device either at the patient's shoulder or in the hands of assistants standing by is mandatory before anesthesia is induced. Two or three minutes of oxygen administration prior to induction, either at high flows in a semi-closed system or in a nonrebreathing system, increases the margin of safety for the anesthesiologist who fears he may cause regurgitation by ventilation prior to intubation (increased intra-abdominal pressure). The entire process from the time of the first anesthetic dose of barbiturate to the inflation of the cuff of the endotracheal tube should require only a few seconds more than the arm to aorta circulation time.

We have already seen that vomiting and aspiration can occur following anesthesia as well as during its administration. A patient intubated because of a full stomach before surgery has a full stomach after surgery as well, unless the stomach contents were removed with the specimen. The endotracheal tube in such a case should be allowed to remain in place until the patient is completely awake and able to reach up and take it out himself.

The discomfort from placement of an esophageal blocking balloon to prevent regurgitation, as recommended by Guiffrida and Bizarri,[25] is of the same order of magnitude as an awake intubation of the trachea. By placing another object in the pharynx it may also make subsequent tracheal intubation more difficult. For these reasons, many anesthesiologists neglect this method as superfluous except in restricted circumstances when it is the only method available. It is, however, an additional safeguard and is not to be condemned.

Regional Anesthesia

Regional anesthesia is the technique of choice, keeping the patient's protective airway reflexes intact, minimizing the likelihood of vomiting or regurgitation, and maintaining normal voluntary protective movements should vomiting occur. In the case of a hand or forearm injury the technique involves premedication and an axillary or brachial plexus block. In the case of a compound fracture of the tibia, it involves premedication plus a spinal or epidural block. In the case of the patient in delivery, it involves sedation as needed and a saddle block, or caudal or peridural anesthesia.

Even regional anesthesia, however, is not a guarantee against regurgitation or aspiration. A patient under spinal anesthesia can vomit and, lying supine, unable to elevate the upper half of the body, may have difficulty in clearing his pharynx if the anesthesiologist is not vigilant and prepared to lend assistance.

Don't Cut Corners

This concludes our consideration of the patient with a full stomach, the hazards of resulting vomiting and aspiration, their incidence, factors influencing their occurrence, and methods of approaching such problems. You will never know, if you apply these principles, which one of your patients would have died had you not been this careful, just as you will never know which of the babies you have inoculated would have contracted diphtheria, or tetanus, or whooping cough or poliomyelitis had you neglected that procedure. But you will know that you have given your patients the best possible medical care.

References furnished upon request to the author.

Benzydroflumethiazide in the Treatment of Edematous States: A Preliminary Trial*

Leonard P. Caccamo, M. D.

During the past several years many new diuretic drugs have been developed and introduced for the treatment of edematous states. Among these, the benzothiadiazine derivatives have become increasingly prominent. Following the introduction of chlorothiazide, the first of these compounds to appear, newer members of the series have become available so that at the present time at least six different derivatives are in clinical use.[1,2] All are potent diuretic drugs which greatly increase urinary volume and the excretion of sodium chloride, with a lesser increase in the urinary excretion of potassium and bicarbonate.[3] Benzydroflumethiazide, one of the newest members of the series, is the most potent diuretic agent of the group[1,3] and in doses producing an equivalent effect on sodium chloride excretion, benzydroflumethiazide has been reported to cause less potassium loss than do other members of the series.[2,3,4,5]

The present report concerns a preliminary clinical trial of benzydroflumethiazide in the control of edematous states associated primarily with heart disease. A brief review of our findings follows.

Methods and Materials

Eighteen patients between the ages of 21 and 75 years were treated with benzydroflumethiazide. All were clinic patients of St. Elizabeth Hospital, 16 being outpatients. Seventeen had cardiovascular disease which in the majority of cases, was advanced, with considerable cardiac impairment. A certain number also presented complicating conditions, as shown in Table 1. Most of the patients had a history of previous episodes of congestive failure and 7 were in heart failure at the time the study began. The one patient without cardiovascular disease presented manifestations of edema during prolonged steroid therapy for exfoliative dermatitis. The objective of diuretic therapy in every case was the control of edema or the prevention of its recurrence.

Benzydroflumethiazide was administered as tablets, with or without potassium supplement, identified as Naturetin and Naturetin with K, respectively.* As administered, each tablet of Naturetin contained 2.5 or 5 mg. of benzydroflumethiazide, without potassium; each tablet of Naturetin with K contained 2.5 or 5 mg. of benzydroflumethiazide, with 500 mg. of potassium chloride. Initially, 14 of the 18 patients were placed on Naturetin. Of this number, 9 were continued on the drug without potassium, and 5 were subsequently transferred to Naturetin with K when the supply of Naturetin was exhausted. Four of the 18 patients in the series were treated with Naturetin with K throughout. Supplemental potassium as Kaon Elixir was added to the regimen of 4 of the patients during treatment with benzydroflumethiazide.** One of these complained of calf pain on walking after 5 months of treatment with benzydroflumethiazide (5 months on Naturetin and 1 month on Naturetin with K). The other three patients for whom supplemental potassium was prescribed displayed cardiac arrythymias during treatment with the test drug.

Other medications were administered, as indicated, concomitantly with benzydroflumethiazide as shown in Table 1. Chest x-rays were taken of most patients at least once during the study while urinalysis and blood chemistry values were determined in the majority of cases from time to time.

Results

Therapeutic results of treatment with benzydroflumethiazide in a series of 18 cases are summarized in Table 1. It is evident from the table that these results were considered to be satisfactory in 12 cases but unsatisfactory in 6, as judged by weight loss and relief of edema, rales and other symptoms of fluid retention. The single patient without cardiovascular disease, who presented evidence of fluid retention secondary to steroid therapy, was among the 12 who re-

The Author

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*From the Department of Cardiology, St. Elizabeth Hospital, Youngstown, Ohio.

Submitted to the Publication Committee, April 4, 1962.

*Naturetin and Naturetin with K are trade names of E. R. Squibb & Sons.

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Patient	Age and Sex	Race	Diagnosis*	Treatment With Benzydroflumethiazide: Dose (Mg./day)	Duration (days)	Concomitant Medication	Results
JA	29 M	C	RHD with MS, MI, AS, AI	5 (every day or every other day)	251	Digitalis Penicillin	Satisfactory. Initial weight loss of 5 lbs. (158 to 153) followed by gradual gain in weight to 160 lbs. Patient remained asymptomatic during treatment. Chest x-ray revealed clearing of slight pulmonary congestion and less cardiomegaly after treatment with benzydroflumethiazide.
MH	21 F	C	RHD with MS and MI	5	142	Digitalis Penicillin	Satisfactory. Weight loss of 1 lb. (101 to 100) and clearing of rhonchi at right base with patient remaining asymptomatic during treatment.
GP	23 F	C	RHD	5	14	Digitalis	Satisfactory. Weight loss of 5 lbs. (146 to 141) and 2+ edema relieved. No dyspnea nor chest pain though substernal tightness persisted.
MR	74 M	W	HCVD with CHF Emphysema Gastric ulcer	5	320	Digitalis Aminophylline Antacid	Satisfactory. Following an initial weight loss of 6 lbs. (168 to 162), patient showed gradual gain in weight to 176 lbs., followed by a drop to 173 lbs. Blood pressure was controlled (190/90 as compared with control reading of 230/110). Except for some shortness of breath patient was symptom-free during treatment, though chest x-ray showed moderate congestion of both lungs and moderate cardiomegaly.
AE	65 M	W	Hypertension with ASHD	5	147	Digitalis	Satisfactory. Weight loss of 8 lbs. (197 to 189) and reduction of blood pressure from 220/120 to 190/100 were recorded after 3 months of therapy and patient showed no edema and no rales, though occasional precordial pain persisted. During next 7 months patient regained 7 lbs.
AC	59 M	W	HCVD Cardiac cirrhosis	10	124	Digitalis Vitamin K Analog	Satisfactory. Patient had a history of repeated paracenteses during past 10 years, and weight ranged from 235 to 277 lbs. Following treatment, weight dropped from 251 to 242 lbs., basilar rales cleared and patient felt fine. Weight subsequently returned to 251 lbs.
GH	67 M	W	ASHD with CHF Diabetes mellitus	5	138	Digitalis Tolbutamide	Satisfactory. Weight loss of 5 lbs. (176 to 171) accompanied by clearing of basilar rales. Auricular fibrillation present before therapy persisted after therapy.
RB	76 M	C	ASHD with CHF	5	76	Digitalis	Satisfactory. Weight was reduced from 145 to 138 and basilar rales cleared.
VF	63 F	C	ASHD Diabetes mellitus	5	44	Digitalis	Satisfactory. Patient showed weight loss of 6 lbs. (187 to 181) and was relieved of symptoms for a time but symptoms of dyspnea and occasional rales recurred as they had done from time to time with other diuretic therapy.
MC	74 M	W	Cor pulmonale	10	116	Digitalis	Satisfactory. Weight loss of 17 lbs. (160 to 143) plus clearing of lungs and relief of ankle edema.
LJ	59 M	C	Luetic HD Prostatic adenocarcinoma	5	113	Digitalis Stillbestrol	Satisfactory. During first 2 months after patient was placed on therapy he gained 8 lbs. (149 to 157), but after that his weight remained stationary and he was asymptomatic for 3 months.
FH	67 M	C	Exfoliative dermatitis Steroid edema	5	243	Digitalis Triamcinolone	Satisfactory. Initial weight loss of 9 lbs. (123 to 114) followed by a gradual increase in weight to 131 lbs. but patient remained asymptomatic with no ascites nor edema during treatment. Chest x-ray showed lungs clear and heart only slightly enlarged.
DI	57 F	W	RHD with LVH, MS, MI, AF	5	237	Digitalis (Low salt diet)	Unsatisfactory. Following an initial weight loss of 2 lbs. (171 to 169) with lungs clear, patient subsequently gained weight over a period of 5 months up to 185 lbs. with progressively increasing edema. Patient was finally hospitalized for further treatment.
NP	52 M	C	RHD with AI, AS, CHF	5	37	Digitalis Quinidine	Unsatisfactory. Patient gained 6 lbs. (190 to 196) and complained of dizziness. Therapy was discontinued.
CZ	75 F	C	ASHD with CHF Diabetes mellitus	5 to 10	229	Digitalis Tolbutamide	Unsatisfactory. Following an initial weight loss of 23 lbs. (114 to 91) after 3 weeks on therapy, gained up to 107 lbs.; peripheral pitting edema persisted though lungs remained clear. During observation period patient was hospitalized for 2 weeks for treatment of diabetes.
LK	75 M	C	Postmyocardial infarction ASHD with CHF	10	189	Digitalis	Unsatisfactory. During first 2 months of treatment patient showed weight loss of 15 lbs. (196 to 181) and part of this time was symptom-free but edema and dyspnea recurred though lungs remained clear. After 6 months' therapy patient complained of occasional vertigo and benzydroflumethiazide was discontinued.
NH	69 M	W	ASHD with CHF Postmyocardial infarction	10	9	Digitalis	Unsatisfactory. Patient in hospital for treatment of heart condition. During treatment symptoms of auricular fibrillation, basilar rales and edema persisted and after 9 days' therapy patient suddenly expired. Autopsy revealed generalized severe arteriosclerosis, cardiomegaly, healed myocardial infarction and coronary atherosclerosis.
TC	47 M	W	ASHD with CHF Myocardial insufficiency	5 to 10	20	Digitalis Dicumarol Prednisone Propylthiouracil	Unsatisfactory. Patient in hospital for treatment of heart condition. Weight reduced from 134 to 119 lbs. during treatment but symptoms of chest pain, rales and tachycardia persisted. After 20 days' therapy patient suddenly expired. Autopsy revealed severe arteriosclerosis with old and recent myocardial infarction, ascites and acute pulmonary congestion.

*RHD represents rheumatic heart disease
MS represents mitral stenosis
MI represents mitral insufficiency
AS represents aortic stenosis
AI represents aortic insufficiency
HCVD represents hypertensive cardiovascular disease
CHF represents congestive heart failure
ASHD represents arteriosclerotic heart disease
LVH represents left ventricular hypertrophy
AF represents auricular fibrillation

sponded satisfactorily to treatment with the drug under study.

Both patients under treatment in the hospital expired suddenly. Autopsy in each case revealed acute congestive heart failure, generalized severe arteriosclerosis, severe arteriosclerosis of the coronary arteries, healed myocardial infarction and other conditions. These cases will be discussed in some detail later in this report.

In two cases in the series, the patient complained of dizziness during treatment and the drug was withdrawn. This was the only clinical side-effect recorded.

Levels of serum potassium below the lower limit of normal (3.5 mEq./l.) were recorded in 2 cases (3.1 and 3.4 mEq./l.) following treatment but neither of these patients displayed clinical signs of hypopotassemia, such as thirst or muscular weakness, and additional serum potassium values were not determined in either case. Levels of serum potassium declined in the two hospitalized patients, prior to their sudden demise, from 4.7 and 4.8 mEq./l., respectively, before treatment, to 3.9 mEq./l. after treatment in each case.

More than one determination of the concentration of serum potassium was made in only 3 of the 16 outpatient cases. These values remained unchanged (3.5 mEq./l.) in one, rose slightly (3.7 to 5.2 mEq./l.) in another, and rose and then declined in the third case (3.8, 4.9 and 4.1 mEq./l.). High levels of blood urea nitrogen (30 and 33 mg. per cent) were recorded in 2 outpatient cases following treatment with benzydroflumethiazide. In the other case the control value determined 6 months before was 18 mg. per cent. This patient was a 75-year-old man who had had diabetes mellitus in association with arteriosclerotic heart disease for 11 years and who had experienced many previous episodes of congestive heart failure. Urinalyses consistently showed 2+ to 4+ albumin, and sugar and blood chemistry showed high readings of fasting blood sugar (250 to 350 mg. per cent). Results of other laboratory tests were not significant.

Discussion

In this preliminary study the observations indicate that benzydroflumethiazide is an effective oral diuretic agent which may be used to advantage in the treatment of patients with cardiac edema and possibly edema secondary to steroid therapy. Although the study is too limited to justify any definite conclusions, the data suggests that the drug is of the same level of effectiveness as that of other thiazide diuretic drugs already on the market.

The occurrence of sudden death in two cases during treatment with benzydroflumethiazide is disturbing, especially in view of the decline in serum potassium levels recorded in both prior to demise. It should be observed, however, that in neither case did the concentration of serum potassium drop below the lower limit of normal. Both of these patients, moreover, had serious heart disease; one had experienced two attacks of coronary thrombosis and the other had a history of myocardial infarction, both prior to treatment with benzydroflumethiazide. At the time of death, both were critically ill and were receiving concomitant treatment with digitalis and mercurial diuretics as well as other indicated medication. In view of the complicated clinical history in each case, and especially since autopsy revealed adequate reasons why each should have become a therapeutic problem, there probably is no valid basis for assuming that death in these cases was related to the administration of benzydroflumethiazide.

Summary and Conclusions

Eighteen patients with edema associated with heart disease or secondary to steroid therapy were treated with benzydroflumethiazide. Of this number, 16 were treated on an outpatient basis and 2 were in the hospital. The therapeutic results were considered to be satisfactory in 12 cases but unsatisfactory in 6, as judged by weight loss and relief of symptoms of fluid retention. Both hospitalized patients died suddenly during treatment but the complicated clinical history and the critical nature of the illness in each case rule out any definite incrimination of benzydroflumethiazide therapy as a precipitating cause of death.

Two patients complained of dizziness during treatment with benzydroflumethiazide and the drug was withdrawn. No other clinical side-effect was reported.

Benzydroflumethiazide would appear to be an effective oral diuretic agent which may be used to advantage in the treatment of patients with cardiac edema.

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Special Article

Let's Help Our Senior Citizens

John M. Bobbitt, M. D.

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Most of us look forward to the autumn of our lives when we can slow down and relax. Yet there are new problems to be faced as senior citizens. They will become more prominent as the over-65 age group expands in coming years. Of these problems, medical care has perhaps created more furor among our citizenry than any other single issue in the past decade. It has been debated in Congress, in recent presidential campaigns, and is now being carried to the public by panel discussion. The solution in the past has been varied; we must recognize, though, that in many instances our senior citizens have had to obtain their medical care as charity cases. Recently the question has been raised whether or not these old solutions are adequate.

The practice of medicine long has been accepted as a service profession. Physicians readily agree that service is their primary responsibility. The income derived from this service is higher than average. It is felt that most people view this higher income as the reward of prolonged training, responsibility assumed in treating human beings, and long working hours which go with the practice of medicine.

Recently, the income level and physicians' motives have been attacked repeatedly, either directly or by innuendo. Many doctors feel angered and frustrated by these attacks and, as human beings, have retaliated. It must be remembered, however, that smear campaigns produce only distrust. Mutual agreement concerning problems of health care will occur only when antagonists shed their antagonism, call a halt to character assassination, and make a real effort to understand each other. In short, the time has come for an analysis of the real issues.

Three-Fourths of Population Covered

At present, according to the Health Insurance Institute, 75 per cent of persons of all age groups in the United States are covered by some form of hospital and medical insurance. Most are insured either by group or by individual policy issued by private insurance carriers. Others are "insured" through health and welfare funds such as those operated by the United Mine Workers, the Kaiser Corporation and the Meatpackers Union in Chicago. There also is a group whose members are not protected by any form of insurance. Many in this latter group have adequate savings or income to pay for needed medical care. This leaves a group who must seek financial aid from their families or obtain care as indigents. The purpose here is to discuss the problem only as it affects the over-65 age group.

But first we should ask whether or not a problem exists in the over-65 age group. If so, it will be financial in nature. When we examine the lower income group we find that some senior citizens have very little income, some receive social security alone, while others receive social security plus a pension. The social security checks vary, depending upon the amount paid into the fund, the number of dependents, and the age of the recipient when he first draws benefits. Thus the income of this group is variable, but it is likely to be inadequate to cover large hospital, doctor, or nursing home bills. In the past doctors have willingly cared for these people regardless of their ability to pay. I am sure that they will continue to do so. But most people want to maintain their independence and self-respect. They do not want charity. Nor do they want to be a burden to their children. Even if a person has a moral responsibility to help his mother and dad, he may not have the needed cash, at the needed moment, nor should anyone be asked to sacrifice his life savings to a medical catastrophe. Then, too, the cost of hospital care has risen to new heights. Hospitals no longer feel justified in charging regular patients, already burdened with illness, with the cost of more charity. Consider-

Submitted to the Publication Committee, February 27, 1962.

ing these facts, we can see that a need exists. How can we answer this need for medical care for the aged? If the senior citizen with a low income does not want charity, what provision should we make?

Government Subsidy

One method for solving the problem is by paying these medical bills through direct government subsidy. The trouble here is that government eventually exercises control over the nature of medical practice. Regimentation, both of patient and physician, follows. Such has occurred in England. John Bull is now learning that socialization is also expensive. In addition, it tends to eliminate competition which, in turn, will lower the quality of the product—in this case, medical care. Certainly it is against the principles of free enterprise on which our nation has always flourished.

Private Insurance Carriers

A second method would be to insure these people through private insurance carriers. It should be mentioned at this time that 53 per cent of our senior citizens already are covered by health insurance. It is estimated by the Health Insurance Institute that by 1970 ninety per cent of the over-65 age group will be covered by private health insurance if present trends continue. Any individual covered by this insurance has complete freedom of choice with regard to hospital and physician. Thus, competition is maintained. The insured can obtain medical care in any of the states. Protection by health insurance has proved very effective in the past. There are now many companies offering such insurance to the over-65 age group, and at reasonable rates. Many can continue the insurance in force at the time of their retirement. Yet health insurance is not foolproof unless it embraces certain features.

Necessary Features

First, all insurance policies issued to these people or, for that matter, to anyone, should be noncancellable, that is, the insurance company would not have the right to cancel a policy because the insured has contracted cancer, heart disease, or other chronic disease. The insured must be free from the fear of losing his protection.

Second, such policies should provide minimal coverage for hospital costs and physician fees. There also must be some provision for nursing home care. Only where there is adequate coverage will there be true protection.

Minimum coverage for hospitals and nursing homes can be estimated on a cost basis. The minimum coverage for physicians is more difficult to ascertain. A doctor can figure the actual cost per patient for running his office. But it becomes difficult to determine the minimum fee for his time, knowledge, and the responsibility he assumes. I am sure, however, that an equitable fee system could be worked out.

In many instances physicians have taken the initiative in setting reduced fees for so-called service cases. In other words, doctors have set lower fees for the low income group. One example is the doctors' own health insurance plan, Blue Shield. Most Blue Shield plans have a service feature whereby the physician agrees to charge the low income group no more than the insurance allows. A second example recently has occurred in St. Louis. The medical society there established, and now supports, an agency where persons of low income may apply for reduced medical fees. These are only two examples but they demonstrate the willingness of most doctors to do their part by accepting equitable fees based on the ability to pay.

Indemnity Feature

One final word on health insurance. It is desirable to have a deductible, or indemnity, feature in such policies, that is, the patient pays the first twenty, thirty or fifty dollars on his yearly medical bill. Such a feature was included in the King-Anderson bill. Under this proposal, the individual would pay twenty dollars on the first day, then ten dollars a day for the first nine days of hospitalization. The purpose of the feature is to discourage the demand for unnecessary hospitalization. An added benefit is that the cost of health insurance is reduced when unnecessary utilization of health care facilities is minimized.

The Dragon Enters

The reader will note that so far, no reference to financing such a program of health insurance has been made. Here lies the area wherein most of the conflict has arisen. Proponents and opponents of social security financing, financing through general tax funds, or federal-state matching funds, have exhausted the repertoire of fact and fancy, to no conclusion. So a few points should be re-stated. Let us begin with some general considerations.

General Considerations

The question of financial contribution by the recipients of medical care has been discussed at length by all parties. It is the feeling of some that to have a man declare his income and contribute accordingly is a degrading process. They believe it makes paupers of people. So they say that the means test is taboo. We should never

forget though, that our entire life is a series of means tests. We impose a means test when we buy hamburger instead of steak, a compact car instead of a limousine. Our own government imposes a means test when a person applies for care for a non-service connected disease in a veterans hospital. Labor unions use a means test in determining benefits from welfare funds or in giving strike benefits. This is as it should be. The means test, properly applied, is not degrading. Physicians do not want any one to be made to feel like a pauper, but the profession strongly supports the principle of allowing all individuals to contribute to their own welfare according to their ability. Only then can they be useful, responsible citizens. So, again, the means test as such is not degrading.

When an individual has his entire welfare provided for him, he tends to lose his initiative and sense of personal responsibility. Real loss of self-respect comes through total dependency on the state or some other organization. Such an individual no longer can hold his head up as a useful, contributing citizen. He is in the position of taking from his neighbor while giving nothing in return. A sense of personal responsibility must be encouraged if this nation is to survive. President Kennedy referred to this in his inaugural address when he stated that we should "ask not what our country can do for us but rather what can we do for our country."

We know that many senior citizens need help in some degree. But, as pointed out earlier, the need is variable. The man with the lowest income will need more help than the one who has more. Is it immoral to let these people help themselves according to their ability? I believe not. Whether a man contributes fifty cents, a dollar, or five dollars a month toward the cost of his health insurance premium should depend upon his relative income. He thus would assume some measure of responsibility for his own welfare. He would really be helping his country, since the cost to the government (and taxpayer) would be definitely reduced. I might add, too, that if the individual's health needs are protected though health insurance no hospital nor physician need know whether the patient has paid all or just part of the premium. Nor will we care. So much for general considerations. Let me next discuss social security as one method of financing health care.

The Social Security Method

First of all, social security by statute is a tax. It has been interpreted as such also by the United States Supreme Court. Why? Because money paid into the social security fund is used for current payments. Taxes are raised if the fund begins to show a deficit. At present, social security taxes are levied against the first $4,800 of annual income. This can change, of course. But it points out that the man with an annual income of $4,800 would pay the same amount of tax for a medical program as the man with a $50,000 income! Such a situation is grossly inequitable as it places the larger proportionate burden on people with lower incomes.

We must remember also that any social security tax levied against the individual is levied against his employer as well. If social security tax rates are raised to pay for a medical care plan, employers will feel an added pinch as the increased tax raises operating costs. Profits will decrease unless offset by an increase in prices. Another way to meet this increased cost is by automation which, of course, results in more unemployment. There is an old law of economics which states that when an item becomes unprofitable to produce, it will cease to be produced. For this reason reduced profits may result in reduced production and further layoffs. To summarize, increased costs may lead to reduced employment, increased prices, or smaller profits and frequently, to all three. It is important, too, that as profits fall, federal tax revenues also fall.

Senior Citizens Not Covered

Finally, we must remember that some four million of our senior citizens are not covered by social security. Any plan financed through social security would therefore not protect all these people. The supporters of social security financing say that those not receiving social security will have to be protected through some other plan. It seems unnecessarily inefficient and expensive, however, to have two plans in operation at the same time. We shall remember, too, as mentioned earlier, that many thousands of our senior citizens can well afford to pay their own way. It almost seems immoral to have the little taxpayer assume the burden, through a compulsory social security tax, of paying for the health care of members of this particular group, for many of these senior citizens have higher incomes than many of those who will pay the tax.

General Tax Revenue Method

We come next to financing with general tax revenues. Unquestionably such a method places an added burden on our national budget. Yet it seems more reasonable to place the burden here than on the little taxpayer, as called for under the social security plan. Perhaps the burden would not be nearly so great if the suggestions

regarding private health insurance were followed. The main deterrent to using state matching funds is that many state budgets already are strained to the breaking point. They can stand very little added expense. Then, too, it probably is easier to run one single, uniform program if it is financed from one source.

There are numerous mechanisms by which health insurance premiums could be paid. I am sure that the Congress and the Administration know considerably more about this than I. One suggestion, however, is the use of a check-off system, in which the individual would apply to some private insurance carrier for health insurance. When the policy was issued, he would take it to his local Health, Education and Welfare (HEW) office and fill out an application for partial reimbursement of the premium. Giving false information on such an application, if proved, would be fraudulent, of course. When the application was accepted by HEW, the individual would forward his part of the premium to Washington. With this money would go a special punched card with the individual's social security number for indexing. This would permit government processing of the information by electronic means. It becomes a simple matter, then, for the federal government to reimburse the insurance carrier on a monthly or quarterly basis for the full amount due on all policies held by participants under the program who carried their insurance with that particular company. If the individual allows his insurance to lapse through nonpayment, it will be immediately known by HEW in Washington when the partial premium is not received.

It might be difficult to check for fraud under such a system; a spot check of applications by HEW officials probably would be required. Of course, information on the application could be checked against income tax returns. A couple over 65 with less than $2,400 annual income, however, pays no income tax. Details of the entire system, including costs, would require more time than can be allowed here.

If general tax revenue were used to support a health insurance program as herein described, the spirit of free enterprise would be maintained, even encouraged. Retired persons would be free to obtain their own health insurance and the insurance companies would be stimulated to keep costs down by the resulting free competition. The government would not have to establish a large department to handle a new medical insurance program. Thus the expense to the taxpayer would be kept to a minimum. But, most important, retired persons who hesitate to seek medical care for monetary reasons would feel free to do so. For health insurance would be available to them regardless of ability to pay. With this program we really could help our senior citizens.

An Admirable Constancy

The Pharmaceutical Manufacturers Association, which represents 141 corporate members who produce 95 per cent of the nation's prescribed medicines, has already released some interesting and encouraging facts. Despite the harassment of a prolonged investigation often characterized by sensationalism, the pharmaceutical industry spent 13 per cent more on research and development in 1961 than in the year previous. The pharmaceutical industry's investment in research is now three times that of average industry. In the period from 1959 to 1961 nearly 500 scientists were added to the staffs of 23 larger companies.

To offset the 13 per cent increase in research spending, the sales of prescribed drugs over the same period increased only 5 per cent world-wide. It takes financial courage as well as scientific competence to operate in this field, and doctors and patients alike respect this all the more as they learn the true facts.

It is estimated that in 1962 members of the association will spend $268 million on research as against $245.3 million in 1961, and another 600 scientists will be added to the payrolls. Since faith is the substance of things hoped for, the companies base their faith on new and improved products as a result of increased research, which in turn leads to increased demand and sales. The industry's faith in its competence is well founded on past performance. It will be supported by those it serves.—New York State Journal of Medicine.

The President's Page

Our Responsibilities

THOSE of you who were privileged to hear the presentations of Dr. George M. Fister, the President of the American Medical Association, and your Immediate Past President, Dr. D. E. Greeneltch, at The Greenbrier, must have sensed the extreme urgency for the complete participation by the members of our profession against the continuing threats to American medicine. There should be no letup in our efforts to preserve our voluntary, free choice medical care system.

It has been said, "Medicine is an institution of service to mankind." Our patients look to us for leadership in our communities and, as such, expect us to guide them significantly in their civic and political activities. "The Principles of Medical Ethics," published by the AMA, states: "The responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well being of the individual and the community."

The doctor's duty to his community goes far beyond that of most citizens. Besides being a healer of mankind and a family confidant, he should assume a greater share of the responsibilities in public affairs. Most of us are more than qualified to assume these responsibilities—and this we must do. This is not to say that we must become politicians as a group, but each of us should exert his right as a private citizen in all matters of public interest. We must make every effort to educate the public on the effect every government health scheme will have on the quality of medical care. These educational attempts on our part should be honest, forthright interpretations which should clarify what government regulations would do to the American doctors, and at the same time and perhaps more important, how these regulations would effect the American public.

As respected members of our respective communities, let all of us take up this challenge and exert our full effort and influence towards bettering our community, our State, and our Country. Our ultimate reward will be a better understanding of the problems of our beloved profession and the enhancement of the image of our profession to our fellow citizens.

L. J. Pace, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 346-0551.

EDITORIALS

The new president of the West Virginia State Medical Association, Dr. L. J. Pace of Princeton, is well-versed in the activities of organized medicine on the local, state and national levels. Physicians in the State are fortunate indeed to have as their leader during the coming year a man who has the ability and initiative to meet and help solve the many problems now confronting the medical and allied professions.

L. J. PACE, M. D.

Doctor Pace has been an active member of the Association for nearly a quarter of a century and has served a term as president of the Mercer County Medical Society. He was elected to two terms as a member of the Council of the State Medical Association and his outstanding work was recognized when his colleagues named him vice president in 1960 and president elect in 1961.

A native of Harrisonburg, Virginia, Doctor Pace received his M. D. degree from the University of Virginia School of Medicine in 1934. He was licensed to practice in West Virginia in 1937 and located in Princeton, where he has practiced continuously with the exception of the years he was on active duty with the armed forces.

During World War II, he was in the Medical Corps of the United States Army and served overseas in England and with the Field Hospital which was in the invasion of Normandy. He received three battle stars, and was released in 1946 with the rank of Captain.

He has been vitally interested in mental health and served for two terms as president of the Mercer County Chapter of the Mental Health

L. J. Pace, M. D.

Association. He also served as chairman of the Mental Health Committee of the State Medical Association and is a charter member and past president of the Parents Association for Mentally and Physically Handicapped Children in Mercer County.

He married the former Nettie Zell Elswick of Richlands, Virginia, and they have three children, Lawrence J. Jr., at home, Margaret Ann, a student at Marshall University, and Charles Walter, a student at Princeton High School.

We are confident that Doctor Pace's term as president will be highly successful and that he will have the full support and cooperation of the members of the Association.

'BEST MEETING WE EVER HAD'

The 95th Convention is sufficiently in the past to make some sober reflections on the proceedings. In the words of our beloved Charles Lively, "It was the best meeting we ever had." Every member throughout the year must have become aware of the courageous, skillful, unselfish devotion of our president to his task. At a time of medical crises the Association could not have had a better qualified shepherd. At the Convention Doctor Greeneltch was given charms, plaques and resolutions attesting to his year of glorious service, but all this cannot equal a word of personal respect and affection. Why not write him at 2000 Eoff Street, Wheeling?

The scientific sessions were superb in all sections. The Program Committee's efforts in commandeering the best in medicine resulted in an outstanding program and improved attendance.

The lovely Greenbrier undoubtedly gives our annual meeting a unique place among medical conventions. It gives us an ideal place for scientific assemblies and exhibits; an opportunity to engage in favorite sports, to enjoy rare moments of relaxation; and it has given our membership a spirit of comaraderie and unity that is hard to establish in the usual city convention where membership is scattered over many hotels. It has also provided attractive bait for guest speakers. The Greenbrier is hard to resist.

In this self-congratulatory mood let us not lose sight of at least one area where improvement is possible. The meetings of the House of Delegates were characterized by the usual absence and apathy. There is a growing feeling that the work of the West Virginia State Medical Association can be handled best by officers, council, and committees; that the work of the House of Delegates is out-dated. The Association needs to hear from its component societies through its constituted delegates, and the county societies need to receive information concerning Association affairs directly from those delegates. In no other way can the Association maintain grass roots interest and support. It is in those heated debates where the sparks fly, that interest is kindled, and a society takes fire.

If we are to have a live Association, we must have creative participation from its membership through the House of Delegates. Perhaps you have some suggestions concerning the improvement of our annual Convention. If so, write *The Journal.*

FITTING TRIBUTES

Few men in the country participated more actively in the campaign against the King-Anderson bill than Dr. D. E. Greeneltch, our immediate past president, and Mr. John Pompelli, the AMA field representative assigned to West Virginia during the past 18 months.

Much attention was focused on West Virginia in the midst of the heated controversy, and Doctor Greeneltch played a leading role in proving that the Kerr-Mills (MAA) program could be implemented and operated efficiently if given a chance. He deserves our praise for a job well-done.

The following resolution was presented by Dr. James S. Klumpp before the Association's House of Delegates, following which Doctor Greeneltch was given a standing ovation:

WHEREAS, In the light of history of human events, the occurrence of political, social or economic crises affecting the welfare of humanity has always produced men of courage, zeal and understanding, who rise to the occasion in noteworthy manner; and,

WHEREAS, Our incumbent President, Dr. D. E. Greeneltch, has so unselfishly devoted his talents of leadership, and has sacrificed so much time from family and professional life in the fight to provide and maintain an equitable and adequate means of health care for our senior citizens; and,

WHEREAS, These efforts have produced local, state and national repercussions of our determination to preserve essential professional and humanitarian freedoms:

THEREFORE, BE IT RESOLVED by the House of Delegates of the West Virginia State Medical Association, That, as elected representatives of the organized medical profession in this State, and as responsible citizens, we formally express our sincere and heart-felt thanks to Doctor Greeneltch, and do hereby commend him for the superior qualities of leadership shown in all of his presidential activities, with particular reference to those associated with programs for health care of the aged; and,

BE IT FURTHER RESOLVED, That the Chairman of the Council be requested to transmit an authenticated copy of this resolution to Doctor

Greeneltch and that the Executive Secretary be directed to spread a copy of this resolution in the official minutes of this Association.

Mr. John Pompelli traveled extensively throughout the State during the trying times. His knowledge of current legislation was of much help, as was his willingness to meet with physicians to discuss the basic issues and formulate plans to work toward defeat of King-Anderson legislation.

We are sorry to report that Mr. Pompelli has been transferred by the AMA to another assignment on the West Coast, and that he will be leaving to assume his new duties early in November.

Although we will miss his capable guidance and counsel, we wish him unbounded success in his new position. Our admiration for Mr. Pompelli is best expressed in the following resolution which was presented by Doctor Klumpp before the House of Delegates:

WHEREAS, Ever since the activation of Kerr-Mills legislation in West Virginia and the concomitant economic and political activities in opposition to Social Security coverage of aged health care, the medical profession in this State has had access to the valued advice and the organizational acumen of one John Pompelli, Field Representative of the American Medical Association; and,

WHEREAS, During this trying period he has been indefatigable in the efforts made to crystallize sentiment against the enactment of such compulsory legislation and for the continuance of professional freedoms associated with our responsibilities to our senior citizens; and,

WHEREAS, Our parent organization has seen fit to reward Mr. Pompelli with a change in duty status to another area of the United States, a change which will be a great loss to all of us:

THEREFORE, BE IT RESOLVED by the House of Delegates of the West Virginia State Medical Association, That our Executive Secretary be directed to transmit a formal expression of our gratitude to Mr. Pompelli, and;

BE IT FURTHER RESOLVED, That a copy of this resolution shall be sent to Mr. Aubrey D. Gates, Director of the Field Service Division of the American Medical Association.

RESPECT FOR WALTER E. VEST

Walter E. Vest, M. D., a past president of the West Virginia State Medical Association and Editor of *The Journal* for more than a quarter of a century, died in Huntington on January 28, 1962. The following eulogy in honor of the late Doctor Vest was presented before the House of Delegates by Dr. James S. Klumpp of Huntington:

In His almighty wisdom, God has seen fit to remove from our midst one of the stalwarts of West Virginia medicine. Walter Edward Vest really enjoyed a long and full life. Professionally he attained wide recognition in his chosen field of internal medicine. He was a true physician, a devoted husband, a good father, and a real Christian gentleman. He gave instinctively of his time, energy and experience to the advancement of knowledge, welfare and the influence of organized medicine in his community, his state and in the nation. He was a man of varied and wide-spread interests. He maintained throughout the years an active role in the affairs of religious, general and medical educational facilities. For some twenty years he served as a delegate to the American Medical Association; he served as a member of important AMA committees. He served on the Council and as president of the West Virginia State Medical Association. He was a member of the editorial board and Editor-in-Chief of *The West Virginia Medical Journal*. He was faithful in attendance at county society, state and national meetings. He gave freely of his advice to medical students and medical graduates alike. In faith, he was a true physician and a respected member of the healing arts profession. May God grant his soul eternal rest.

The Answer: Enter Politics

So often one finds medical people unwilling—too preoccupied—to work in political organizations. Yet if you are to expend your influence in public affairs, you must participate in politics, for it is politics that determines government—the government which today determines the conditions of your lives.

Therefore, join the political party that you think is nearest right on the most important issues. You won't agree with it on everything, any more than you agree on every issue with your classmates, or with your medical society, or even with your wife. But you don't pull out of those associations whenever you disagree. Rather, you stay in and try to move your associates in the direction you believe is right.

Just so, associate yourself with the party having principles and programs with which you find yourself in closest agreement, and work in and through it to help select and then to help elect good men and women to public office at every level of government.

In addition, more medical people have to be willing to be candidates for public office. That's tough, I can testify. But both patriotism and good sense require that all of our citizens, no matter how specialized their training, be willing to sacrifice their careers to go into public service in peacetime, just as their sons are called upon to sacrifice their careers to go into the armed services in wartime.

Only as you do these things—and not just discuss them—will there be hope. The most wonderful thing about our country—the thing which we must preserve at all costs—is the privilege we have of changing the things we don't like. Thank God our system is such that whenever conditions are bad, or don't meet our standards, we can correct them—if we will work in public affairs.

The way to begin is with ideas and principles, to get persons and parties committed to them, translate them into programs, and put them into practice.—From a medical school commencement address by the Hon. Walter H. Judd, which appeared in the Journal of the Iowa Medical Society.

The cruelest lies are often told in silence.—Robert Louis Stevenson.

GENERAL NEWS

Dr. L. J. Pace Installed as President Of State Medical Association

Dr. L. J. Pace of Princeton was installed as President of the West Virginia State Medical Association by Dr. George M. Fister, President of the American Medical Association, at the final session of the House of Delegates during the 95th Annual Meeting at The Greenbrier on Saturday afternoon, August 25.

He succeeds Dr. D. E. Greeneltch of Wheeling, who automatically becomes Chairman of the Council.

Dr. L. J. Pace of Princeton, left, was installed as president of the West Virginia State Medical Association by Dr. George M. Fister, second from right, president of the American Medical Association. He succeeds Dr. D. E. Greeneltch, right, who will serve as Chairman of the Council during the coming year. Dr. Charles L. Goodhand of Parkersburg, second from left, was named president elect.

Doctor Pace served four years as a member of the Council and was elected vice president in 1960 and president elect in 1961.

Dr. Charles L. Goodhand President Elect

Dr. Charles L. Goodhand of Parkersburg, who was named vice president in 1961, was named president elect. He will be installed as president at the 96th Annual Meeting at The Greenbrier in August, 1963.

Dr. Albert C. Esposito of Huntington, who has served for the past three years as a member of the Council, was elected vice president. He also served during the past year as chairman of the Resolutions Committee.

Dr. Daniel N. Barber of Charleston was reelected treasurer, a post he has held since 1958.

Dr. John W. Hash of Charleston, who has served during the past year as Chairman of the Council, will serve as Councillor-at-Large during the Association year 1962-63.

Three New Members of The Council

Three new members of Council were elected as follows:

Dr. Charles L. Leonard of Elkins (second district); Dr. I. Ewen Taylor of Huntington (fourth district); and Dr. William B. Rossman of Charleston (sixth district).

Doctor Leonard succeeds Dr. S. Elizabeth McFetridge of Shepherdstown, who had served two terms and was not eligible for reelection. Doctor Taylor was elected to serve the unexpired term of Doctor Esposito, who was named vice president. Doctor Rossman succeeds Dr. T. P. Mantz of Charleston.

Four Council Members Reelected

Four members of the Council were reelected to serve terms of two years. They had served but one term and were eligible for reelection. They are as follows:

Dr. Paul P. Warden of Grafton (first district); Dr. Richard V. Lynch, Jr., of Clarksburg (third district); Dr. Richard W. Corbitt of Parkersburg (fourth district); and Dr. Ward Wylie of Mullens (fifth district).

Hold-over members of the Council who will serve during 1962-63 are as follows:

Dr. Richard E. Flood of Weirton (first district); Dr. Justus C. Pickett of Morgantown (second district); Dr. John E. Echols of Richwood (third district); Dr. Harold Van Hoose of Man (fifth district); and Dr. C. A. Smith of Beckley (sixth district).

Doctor Hoffman Reelected AMA Delegate

Dr. Charles A. Hoffman of Huntington was reelected AMA delegate from West Virginia and Dr. D. E. Greeneltch of Wheeling succeeded Dr. J. C. Huffman of Buckhannon as AMA alternate. Each will serve a two-year term beginning January 1, 1963. Dr. Frank J. Holroyd of Princeton is the hold-over AMA delegate and Dr. Thomas G. Reed of Charleston hold-over alternate.

New President Native of Virginia

Doctor Pace, the new president, was born at Harrisonburg, Virginia. He attended the public schools in that city and received his M. D. degree from the University of Virginia School of Medicine in 1934. He served a two-year internship in medicine and surgery at the University of Virginia Hospital, 1934-36, and also served a residency in obstetrics and gynecology at that Hospital, 1936-37.

Doctor Pace was licensed to practice in West Virginia in 1937 and located in Princeton. He entered the

Medical Corps of the United States Army in 1942 and served overseas in England and with the Field Hospital which was in the invasion of Normandy. He received three battle stars. He also served as Chief of Surgery at the 110th General Hospital. He was released in 1946 with the rank of Captain.

He served as president of the Mercer County Medical Society in 1941 and as Program Chairman of the State Medical Association, 1951-52. He served two terms as a member of the Council and was named vice president in 1960 and president elect in 1961.

Doctor Pace has been interested in mental health and served two terms as president of the Mercer County Chapter of the Mental Health Association. He has served as chairman of the Mental Health Committee of the State Medical Association and is a charter member and past president of the Parents Association for Mentally and Physically Handicapped Children in Mercer County.

He married the former Nettie Zell Elswick of Richlands, Virginia, and they have three children, Lawrence J., Jr., Margaret Ann and Charles Walter.

Program Committee for 1963

Dr. Henry F. Warden, Jr., of Bluefield has been named by Dr. L. J. Pace of Princeton, President of the State Medical Association, as chairman of the committee which will arrange the program for the 96th Annual Meeting at The Greenbrier in White Sulphur Springs, August 22-24, 1963.

The other members of the committee are Drs. Albert C. Esposito of Huntington and Maynard P. Pride of Morgantown.

The President Elect

Dr. Charles L. Goodhand, the president elect, is a native of Chester, Maryland. He was graduated from Western Maryland College and received his M. D. degree from the University of Maryland School of Medicine in 1934.

The Rev. Robert P. Varley, Th. D., left, and AMA Field Representative John W. Pompelli of Chicago, right, are shown with their wives following the Presidential Dinner. Doctor Varley, Rector of St. Peter's Episcopal Church in Salisbury, Maryland, was guest speaker at the dinner honoring AMA President Dr. George M. Fister.

He served an internship at University Hospital, Baltimore, Maryland, 1934-37, and had residency training at Baltimore City Hospital, 1937-38. He was licensed to practice in West Virginia in 1938.

Doctor Goodhand was certified by the American Board of Obstetrics and Gynecology in 1947 and served as President of the Parkersburg Academy of Medicine in 1951. He served three years as a member of the Council prior to his election as vice president in 1961. He became an associate editor of *The Journal* in 1961.

During World War II, Doctor Goodhand served in the Medical Corps of the United States Army and was released in 1946 with the rank of Lieutenant Colonel.

Resolutions Adopted During Meeting

The Committee on Resolutions held an open hearing on three resolutions lodged with the executive secretary at least two weeks prior to the first day of the meeting. The meeting was held on Thursday afternoon, August 23, and was attended by several interested physicians in addition to members of the Committee.

Dr. D. E. Greeneltch of Wheeling, left, immediate past president of the State Medical Association, and Dr. John W. Hash of Charleston, center, immediate past chairman of the Council, are shown with State Welfare Commissioner W. Bernard Smith prior to Mr. Smith's appearance before the Council. In the other photo, Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army, center, is shown with Dr. Frank H. Mayfield of Cincinnati, left, a past president of the Ohio State Medical Association, and Dr. Thomas G. Folsom of Huntington.

Dr. Russel Kessel of Charleston, center, is shown with Paul Brooks of Sissonville and Paul E. Lanham of Charleston, recipients of four-year scholarships to the West Virginia University School of Medicine.

The report of the Committee, which appears elsewhere in this issue of *The Journal*, includes the resolutions and a report of the action thereon by the House of Delegates. One of the resolutions calls for the establishment of a Medical Examiner's System in West Virginia, a second reiterated the Association's opposition to King-Anderson type legislation, and the third regards adoption of a law covering who may sign for autopsy consent. Three courtesy resolutions introduced by Dr. James S. Klumpp were adopted unanimously.

Action on Proposed Amendment

An amendment to the By-Laws affecting qualifications for honorary membership in the State Medical Association was offered at the first session of the House of Delegates on Wednesday evening, August 22, by Dr. Richard E. Flood of Weirton, chairman of the Committee on Constitution and By-Laws.

The Amendment, which was adopted by the House of Delegates during the final session on Saturday afternoon, August 25, has the effect of relaxing requirements for honorary membership. It stipulates that only the last five years of the required 15 years regular membership before reaching the age of seventy years must have been as a member in a component society of the State Medical Association.

Addresses by Drs. Greeneltch and Fister

Dr. D. E. Greeneltch of Wheeling, the retiring president, delivered his Presidential Address at the first session of the House of Delegates. The President of the American Medical Association, Dr. George M. Fister of Ogden, Utah, was the guest speaker at the final session of the House of Delegates on Saturday afternoon.

The complete text of Doctor Greeneltch's address appears elsewhere in this issue of *The Journal*, beginning on Page 295. Doctor Fister's address will appear in the November issue.

Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army and a native of Parkersburg, was the first speaker at the opening session on Thursday morning, August 23. His address also will appear in a future issue of *The Journal*.

Medical Scholarships Awarded

Paul Brooks of Sissonville and Paul E. Lanham of Charleston were introduced by Dr. Russel Kessel of Charleston, immediate past chairman of the Medical Education, Scholarships and Hospitals Committee, as recipients of the 1962 medical scholarship awards.

Brooks and Lanham are the fifth and sixth students to receive medical scholarships under the program which was inaugurated in 1958. In previous years, only a single scholarship was awarded.

The other four scholarship winners were Larry Hemmings of Charleston, 1958, Terry T. Tallman of Alma, Tyler County, 1959, Glenn Buchanan of Gilbert, Mingo County, 1960, and Clare D. Edman of Parkersburg in 1961. Doctor Hemmings received his M. D. degree in June at the West Virginia University School of Medicine and is now serving an internship at the United States Naval Hospital in Bethesda, Maryland.

1963 Meeting at The Greenbrier

The House of Delegates, prior to adjournment on Saturday afternoon, voted unanimously to return to The Greenbrier for the 96th Annual Meeting in 1963. The Council fixed August 22-24 as the dates for the coming year.

The total attendance at the meeting was 714, which compares with 756 in 1961. The physician registration was 422 as compared with 449 last year. The Auxiliary registration was 191 and the total registration for exhibitors and other guests was 101.

1963 Meeting at The Greenbrier

At the final session of the House of Delegates on Saturday, August 25, it was ordered by the unanimous vote of the delegates present that the 96th Annual Meeting of the State Medical Association be held at The Greenbrier in 1963. The meeting is scheduled for August 22-24.

Gastroenterology Meeting in Chicago

The 27th Annual Meeting of the American College of Gastroenterology will be held at the Morrison Hotel in Chicago, October 29-31. Drs. Owen H. Wangensteen of Minneapolis and I. Snapper of Brooklyn, New York, will serve as moderators of the annual course in postgraduate gastroenterology which will be held following the convention, November 1-3.

Further information concerning the program may be obtained by writing to the American College of Gastroenterology, 33 West 60th Street, New York 23, New York.

Medical Technologists Meeting

The Annual Meeting of the West Virginia State Society of Medical Technologists will be held in Clarksburg, May 3-4, 1963. Further information concerning the meeting will appear in a future issue of *The Journal*.

MLB Licenses 17 Physicians To Practice in State

The Medical Licensing Board has announced that 17 physicians have been licensed by reciprocity to practice medicine in West Virginia. The Board met in Charleston on July 23.

The following is a list of physicians licensed by reciprocity:

Amsel, Melvyn Bernard, Elkins
Bauer, Harry Christian, Wheeling
Burgess, Clyde Albert, Berkeley Springs
Davidson, Paul Colwell, Morgantown
Farrish, Grover Cleveland Morrison, Whitesville

Gatherum, David Hoge, Bluefield
Goodwin, Andrew Wirt, II, Charleston
Goshen, Charles Ernest, Morgantown
Hanna, William Robert, Pittsburgh, Pa.
Hunter, Glen Gene, Chesapeake, Ohio
Kapcar, Andrew John, Jr., Charleston

Kosar, George Stephen, Weirton
Mattill, Robert Lee, Huntington
Perry, Robert Stephen, Wheeling
Prillaman, Paul Ellis, Jr., Ronceverte
Reed, Robert Jeffrey, III, Wheeling
Shaw, Walter Morgan, Moundsville

The fall meeting of the Medical Licensing Board was to be held in Charleston on October 1, 1962.

Neighboring State Presidents Attend Annual Meeting

The presidents of the medical associations of the neighboring states of Ohio, Pennsylvania, Maryland and Virginia were among the honor guests at the 95th Annual Meeting at The Greenbrier in August. The following physicians, all of whom were accompanied by their wives, attended the meeting:

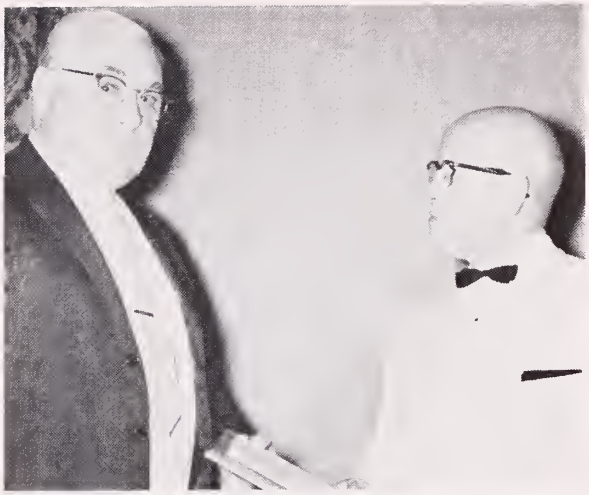
Dr. George J. Hamwi of Columbus, president of the Ohio State Medical Association; Dr. Daniel H. Bee of Indiana, Pennsylvania, president of the Pennsylvania Medical Society; Dr. Charles F. O'Donnell of Baltimore, president of the Medical and Chirurgical Faculty of the State of Maryland; and Dr. Russell Buxton of Newport News, President of the Medical Society of Virginia.

31st Annual AAP Meeting Opens In Chicago, October 27

More than 2,000 persons are expected to attend the 31st annual meeting of the American Academy of Pediatrics at the Palmer House in Chicago, October 27-November 1. Two days of section meetings will precede the usual four days devoted to general sessions.

The sections will have separate programs on surgery, cardiology, allergy, child development and diseases of the chest. There also will be 10 seminars during the first two days.

Further information may be obtained by writing Dr. E. H. Christopherson, Executive Director, American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois.



Dr. Byron W. Steele of Mullens, left, West Virginia's "General Practitioner of the Year" for 1962, receives a plaque from Dr. D. E. Greenelteh of Wheeling, immediate past president.

Plans Completed for Tenth Annual Bluefield Sanitarium Seminar

The 10th Annual Medical Seminar, sponsored by the Bluefield Sanitarium, the Stevens Clinic and the Clinch Valley Clinic, will be held at the Bluefield Country Club in Bluefield on Thursday, October 25.

The one-day meeting will feature a scientific session in the afternoon beginning at 4 o'clock and a social hour and banquet that evening.

Dr. Henry F. Warden, Jr., of Bluefield, Chairman of the Program Committee, announced that two prominent out-of-state physicians have accepted invitations to participate in the scientific session.

The first speaker will be Dr. Angus E. McBryde of Durham, North Carolina, who will present a paper on "The Challenge of Prematurity." Doctor McBryde is Professor of Pediatrics at the Duke University School of Medicine.

"Urologic Problems in Pediatric Practice" will be the subject of a paper which will be presented by Dr. Fred K. Garvey, Professor of Urology at Bowman-Gray School of Medicine, Winston-Salem, North Carolina.

Dr. Harry J. Warthen, Jr., of Richmond, Virginia, will be the speaker at the banquet. His subject will be "Why Did Stonewall Jackson Die."

Doctor Warthen is Associate Professor of Surgery at the Medical College of Virginia and also is Editor of the *Virginia Medical Monthly*. He is recognized as an authority on the history of the Civil War.

ACP Postgraduate Course in Boston

A postgraduate course on "The Rheumatic Diseases—Pathology, Diagnosis and Treatment" will be sponsored by the American College of Physicians in Boston, October 29-November 2. Dr. Theodore B. Bayles will serve as director of the course.

Further information may be obtained by writing the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania.

Pre-Convention Council Meeting At The Greenbrier, Aug. 22

The Pre-Convention meeting of the Council was held at The Greenbrier in White Sulphur Springs on August 22, 1962, with the Chairman, Dr. John W. Hash of Charleston, presiding.

Mr. W. Bernard Smith, Commissioner of the Department of Welfare, appeared before the Council and discussed the various medical programs under the supervision of the Department, with particular emphasis on the MAA and GMH programs.

Mr. Smith said he believed the creation of district review committees throughout the state had done much

Members of the Committee on Nominations are shown during a meeting at The Greenbrier. Seated are Drs. S. Elizabeth McFetridge of Shepherdstown; J. C. Huffman of Buckhannon, chairman, and Harold Van Hoose of Man. Standing: Richard V. Lynch, Jr., of Clarksburg; Albert C. Esposito of Huntington; and Richard E. Flood of Weirton.

to reduce friction between physicians and administrators and other personnel in the local and county level offices.

He also discussed the pilot program conducted in Kanawha County to review the medical eligibility of the caseload under the Aid to Dependent Children Program, and called upon the State Medical Association to cooperate with the Department in asking that the Legislature appropriate more funds to provide for more adequate services under the various welfare programs.

Report of Committee Chairmen

Dr. A. L. Wanner of Wheeling, Chairman of the Mental Health Committee, presented a report in which it was recommended that certain portions of the Mental Health Act be amended. He stated that the proposed amendments applied only to those portions of the Code pertaining to the admission and discharge laws for the mentally ill.

He said that the recommendations resulted from study of the modern laws enacted in other states and consultation with officials of mental health departments in neighboring states.

The Council went on record as accepting and approving the report.

Dr. George R. Callender, Jr., of Charleston, Chairman of the Joint Conference Committee, presented a report on recent developments in the MAA and GMH programs. The Council went on record as commending Doctor Callender and the members of his committee for their splendid work during the past year.

Dr. Ralph H. Nestmann of Charleston, Chairman of the Tuberculosis Committee, appeared before the Council to present a report concerning the two tuberculosis sanatoria in the state. The Council approved the recommendation of his committee that a committee be appointed "to study the trends in the care of the tuberculous ill in the state and in our sanatoria, and to make recommendations regarding future care of these patients."

Report of AMA-ERF Committee

Dr. Earl S. Phillips of Wheeling, Chairman of the AMA-ERF Committee, reported that the campaign to solicit funds for the program had been most successful during the past year.

Doctor Phillips attributed much of the success of the campaign to the $10 voluntary assessment levied against members of the State Medical Association. He recommended that the assessment be continued in 1963.

The Council went on record as approving the report submitted by Doctor Phillips.

State Physicians Praised

Mr. John Pompelli of Chicago, AMA Field Representative, was introduced and spoke briefly. He commended the physicians in West Virginia for their determination in helping to defeat the King-Anderson Bill during the recent session of Congress.

Doctor Hash praised Mr. Pompelli for the manner in which he performed his duties in West Virginia and also informed the Councillors that Mr. Pompelli had been transferred by the AMA to the West Coast, effective shortly after the first of November.

Commendation for Doctor Hash

The Council went on record unanimously commending Dr. John W. Hash for his untiring and loyal service as Chairman of the Council during the past year.

The following members of the Council were present at the meeting:

Dr. John W. Hash of Charleston, Chairman; Dr. D. E. Greeneltch of Wheeling, President; Dr. L. J. Pace of Princeton, President Elect; Dr. Charles L. Goodhand of Parkersburg, Vice President; Dr. Daniel N. Barber of Charleston, Treasurer; Dr. J. C. Huffman of Buckhannon, Councillor-at-Large; and Drs. Paul P. Warden, Grafton; Richard E. Flood, Weirton; S. Elizabeth McFetridge, Shepherdstown; Richard V. Lynch, Jr., Clarksburg; John E. Echols, Richwood; Richard W. Corbitt, Parkersburg; Albert C. Esposito, Huntington; Ward Wylie, Mullens; Harold Van Hoose, Man; Clyde A. Smith, Beckley; and William H. Lively and Jerry Gould of Charleston, executive secretary and executive assistant, respectively.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Charles A. Hoffman of Huntington, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. George F. Evans of Clarksburg, Editor of *The Journal*; Dr. James S. Klumpp, Parliamentarian; Dr. N. H. Dyer of

Charleston, State Director of Health; Dr. George R. Callender, Jr. of Charleston, Chairman of the Joint Conference Committee; Dr. A. L. Wanner of Wheeling, Chairman of the Mental Health Committee; Dr. Ralph H. Nestmann of Charleston, Chairman of the Tuberculosis Committee; Dr. Earl S. Phillips of Wheeling, Chairman of the AMA-ERF Committee; and Drs. Upshur Higginbotham of Bluefield, W. P. Bittinger of Summerlee, Seigle W. Parks of Fairmont, and Stephen D. Ward of Wheeling.

SMA Section on Oph. and Otol. To Meet in Florida, Nov. 12-15

Dr. Albert C. Esposito of Huntington, Secretary of the Section of Ophthalmology and Otolaryngology of the Southern Medical Association, has announced that plans have been completed for the Annual Meeting at the Fontainebleau Hotel in Miami Beach, Florida, November 12-15.

The section meeting will feature two live television clinics. One will be on "Diseases of the Cornea" with Dr. Robert Sexton serving as moderator. Drs. Samuel D. McPherson of Durham, North Carolina, John McKenna of Miami, and Albert Kaufman of Gainesville, Florida, will serve as members of the panel.

The live television clinic on "Surgery of the Cornea" will have Dr. Edward Norton as moderator and the panel will be composed of Drs. Frederick Stocker of Durham, North Carolina, A. G. DeVoe of New York City, and Norman Sanders of Miami, Florida.

Further information may be obtained by writing to Doctor Esposito, 1212 1st Huntington National Bank Building, Huntington, West Virginia.

New Telephone Number

The telephone number has been changed in the headquarters offices of the West Virginia State Medical Association in Charleston. The new number is 346-0551.

J. Stanley Turk New President Of Hospital Association

Mr. J. Stanley Turk of Wheeling was named president elect of the West Virginia Hospital Association at the annual meeting which was held at The Greenbrier in White Sulphur Springs, August 16-18.

Mr. Turk, who has been administrator of the Ohio Valley General Hospital in Wheeling since 1927, will be installed as president at the 1963 meeting which will be held at Oglebay Park, October 9-11.

Steve J. Soltis, administrator of Beckley Memorial Hospital, was installed as president succeeding Charles A. Okey of Weirton. Other new officers for the coming year are as follows: Mother M. Rosaria of Wheeling, vice president; and trustees, Charles L. Showalter, Charleston, Sister M. Palmatia, Morgantown, and Harry J. Edmonds, Hinton.

TB and Health, Thoracic Groups Meet in Beckley, October 9-11

The Annual Meeting of the West Virginia Tuberculosis and Health Association and the West Virginia Thoracic Society will be held at the Beckley-Winn Hotel in Beckley, October 9-11.

A postgraduate course on "Current Concepts of Pulmonary Diseases" will be held on October 9 with Dr. Charles E. Andrews of Morgantown presiding. The course will be sponsored by the West Virginia University School of Medicine and the Tuberculosis and Health Association and Thoracic Society.

Dr. William E. Ruth of Kansas City, Assistant Professor of Medicine at the University of Kansas School of Medicine, and Dr. William W. Stead, Associate Professor of Medicine at Marquette University School of Medicine, will present papers at the one-day meeting. There will be a $10 registration fee in connection with the postgraduate course.

The meeting of the West Virginia Thoracic Society will be held on October 10. Dr. Richard V. Lynch, Jr., of Clarksburg will preside. Papers will be presented by Drs. Ruth and Stead and another out-of-state speaker will be Dr. William S. Blakemore, Professor of Surgery at the University of Pennsylvania School of Medicine.

The annual business meeting of the West Virginia Thoracic Society will be held following the afternoon scientific session.

Medicolegal Symposium in Miami Beach

More than 800 physicians and attorneys are expected to attend a Medicolegal Symposium which will be held at the Americana Hotel in Miami Beach, Florida, March 8-9, 1963.

The two-day meeting will be sponsored by the American Medical Association which has conducted meetings of this type every two years since 1955.

Geriatrics Symposium in Florida

A Postgraduate Symposium on Geriatrics will be held at the Mound Park Hospital in St. Petersburg, Florida, October 18-20, under the joint auspices of the Mound Park Hospital Foundation, the Bay Pines VA Center and the American Academy of General Practice.

AAGP members attending the meeting will be granted 18 hours of Category One Credit. Further information on the Symposium, entitled "The Physician and The Older Patient," may be obtained by writing Dr. M. A. Barton, President, Mound Park Hospital Foundation, St. Petersburg, Florida.

NY Academy of Science Conference

The New York Academy of Sciences will sponsor a conference on "Fetal and Infant Liver Function and Structure" at the Henry Hudson Hotel in New York City, November 7-10.

Further information concerning the meeting may be obtained by writing Mrs. E. T. Minor, 2 East 63rd Street, New York 21, New York.

CAMERA HIGHLIGHTS

95th Annual Meeting

WEST VIRGINIA STATE MEDICAL ASSOCIATION

The Greenbrier

Aug. 23-25, 1962

(Identifying Notes on Page 323)

Standing and Special Committees Named By Doctor Pace

Dr. L. J. Pace of Princeton, President of the West Virginia State Medical Association, has named the standing and special committees which will function during his term of office.

The complete list of committees follows:

STANDING COMMITTEES

Aging

E. Lyle Gage, Bluefield, Chairman; Thomas H. Blake, St. Albans; Myer Bogarad, Weirton; Ray E. Burger, Welch; George R. Callender, Jr., Charleston; William E. Gilmore, Parkersburg; Daniel Hale, Princeton; John I. Markell, Princeton; and Sam Milchin, Bluefield, Virginia.

Budget and Personnel

J. C. Huffman, Buckhannon (1963); John W. Hash, Charleston (1964); and D. E. Greeneltch, Wheeling (1965).

Cancer

John T. Jarrett, Charleston, Chairman; Robert S. Gatherum, Jr., Bluefield; T. P. Mantz, Charleston; Hu C. Myers, Philippi; David W. Palmer, Wheeling; W. Hampton St. Clair, Bluefield; Russell A. Salton, Williamson; C. Truman Thompson, Morgantown; Gordon L. Todd, Jr., Princeton; and Chauncey B. Wright, Huntington.

Conservation of Vision and Hearing

W. W. McKinney, Beckley, Chairman; J. E. Blaydes, Jr., Bluefield; John B. Haley, Charleston; Nime K. Joseph, Wheeling; William K. Marple, Huntington; Ralph W. Ryan, Morgantown; Edwin M. Shepherd, Charleston; and Fred D. White, Bluefield.

Constitution and By-Laws

John J. Mahood, Bluefield, Chairman; Daniel N. Barber and A. C. Chandler, Charleston; Richard E. Flood, Weirton; Frederic C. Goodall, Princeton; S. Elizabeth McFetridge, Shepherdstown; Buford W. McNeer, Hinton; B. B. Richmond, Beckley; and Wade H. St. Clair, Bluefield.

Insurance

Charles A. Hoffman, Huntington, Chairman; Herbert M. Beddow, Charleston; W. P. Bittinger, Summerlee; Peter A. Haley, Charleston; Upshur Higginbotham, Bluefield; Kenneth G. MacDonald, Charleston; Joe E. McCary, Princeton; Paul L. McCuskey, Parkersburg; J. S. Meier, Wheeling; Seigle W. Parks, Fairmont; and Eldon B. Tucker, Morgantown.

Legislative

Frank J. Holroyd, Princeton, Chairman; Don S. Benson, Moundsville; Richard W. Corbitt, Parkersburg; George A. Curry, Morgantown; Joseph L. Curry, Wheeling; A. C. Esposito, Huntington; George F. Evans, Clarksburg; Richard E. Flood, Weirton; Upshur Higginbotham, Bluefield; J. C. Huffman, Buckhannon; Frank V. Langfitt, Clarksburg; Charles W. Merritt, Beckley; David W. Mullins, Logan; Newman H. Newhouse, Charleston; J. C. Pickett, Morgantown; Thomas G. Reed and William B. Rossman, Charleston; William J. Steger, Wheeling; A. J. Villani, Welch; and Ward Wylie, Mullens.

Maternal Welfare

Charles L. Goodhand, Parkersburg, Chairman; Harold D. Almond, Buckhannon; Paul H. Cope, Wheeling; Frederick H. Dobbs, Charleston; N. W. Fugo, Morgantown; C. S. Harrison, Clarksburg; William S. Herold, South Charleston; Edwin J. Humphrey, Huntington; Robert W. Leibold, Wheeling; J. Preston Lilly, Charleston; E. W. McCauley, Bluefield; and A. J. Villani, Welch.

Medical Economics

James S. Klumpp, Huntington, Chairman; George R. Callender, Jr., Charleston; James A. Heckman, Huntington; Henry M. Hills, Jr., Charleston; Charles A. Hoffman, Huntington; Thomas P. Long, Man; Athey R. Lutz, Parkersburg; Seigle W. Parks, Fairmont; J. C. Pickett, Morgantown; W. Fred Richmond, Beckley; Charles M. Scott, Bluefield; A. B. Curry Ellison, Charleston; Harry S. Weeks, Jr., Wheeling; Walter R. Wilkinson, Huntington; and J. D. H. Wilson and Robert S. Wilson, Clarksburg.

Medical Education, Hospitals and Scholarships

J. P. McMullen, Wellsburg, Chairman; Carl B. Hall, Charleston; Thomas L. Harris, Parkersburg; Russel Kessel, Charleston; John M. Moore, Wheeling; Clark K. Sleeth, Morgantown; William A. Thornhill, Jr., Charleston; and M. B. Williams, Wheeling.

Medical Emergencies and Civil Defense

John A. B. Holt, Charleston, Chairman; Norman Bsharah, Poca; W. Alva Deardorff, Charleston; Eugene E. Hutton, Jr., Elkins; Semon M. Lilienfeld, Parsons; E. Leon Linger, Clarksburg; Charles T. Lively, Weston; John J. Mahood, Bluefield; George Miyakawa, Charleston; Ralph W. Ryan, Morgantown; M. D. Reiter, Wheeling; Richard J. Sexton, Charleston; Harlan A. Stiles, Huntington; Glenn F. Van Winkle, South Charleston; and David M. Wayne, Bluefield.

Medico-Legal

George F. Evans, Clarksburg, Chairman; E. M. Clubb, Jr., Weirton; T. Kerr Laird, Montgomery; Richard V. Lynch, Jr., Clarksburg; J. Keith Pickens, Clarksburg; Thomas G. Reed and Paul H. Revercomb, Charleston; James R. Shanklin, Bluefield; and E. Andrew Zepp, Martinsburg.

Mental Health

A. L. Wanner, Wheeling, Chairman; Mildred Mitchell-Bateman, Charleston; Randall Connolly, Vienna; Thomas J. Holbrook, Huntington; W. Parke Johnson, Masontown; Thomas S. Knapp, Charleston; John L. Rittmeyer, Philippi; William B. Rossman, Charleston; Stephen D. Ward, Wheeling; David M. Wayne, Bluefield; and William E. Wilkinson, Beckley.

Military Medical Affairs

Russel Kessel, Charleston, Chairman; Bert Bradford, Charleston; S. S. Bobes, Wheeling; Jess P. Champion, Princeton; A. C. Esposito, Huntington; Charles L. Goodhand, Parkersburg; L. Rush Lambert, Fairmont; Richard V. Lynch, Jr., Clarksburg; Charles M. Scott, Bluefield; and Ward Wylie, Mullens.

Necrology

P. R. Fox, Bluefield, Chairman; Donald H. Lough, Clarksburg; Richard L. Stovall, Princeton; and A. C. Van Reenen, Bluefield.

Program Committee

Henry F. Warden, Jr., Bluefield, Chairman; Albert C. Esposito, Huntington; and Maynard P. Pride, Morgantown.

Public Service Committee

Joseph L. Curry, Wheeling, Chairman; William E. Bray, Jr., Huntington; John T. Chambers, Charleston; C. R. Davisson, Weston; G. Thomas Evans, Fairmont; Logan W. Hovis, Parkersburg; Carl E. Johnson, Morgantown; E. Lee Jones, Wheeling; Charles L. Leonard, Elkins; John J. Mahood, Bluefield; L. E. Neal, Clarksburg; C. A. Smith, Beckley; Everett H. Starcher, Logan; and Stephen D. Ward, Wheeling.

Resolutions

Maynard P. Pride, Morgantown, Chairman; C. R. Davisson, Weston; A. C. Esposito, Huntington; Upshur Higginbotham, Bluefield; Pat A. Tuckwiller, Charleston; and Howard G. Weiler, Wheeling.

Rehabilitation

J. C. Pickett, Morgantown, Chairman; Robert C. Bock, Charleston; C. B. Buffington, Wheeling; Harry F. Cooper, Beckley; James A. Heckman, Huntington; R. T. Humphries, Clarksburg; Thomas S. Knapp and Milton J. Lilly, Jr., Charleston; John R. Parsons, Huntington; and R. R. Raub, Bluefield.

Rural Health

Charles E. Staats, Charleston, Chairman; Andrew E. Amick, Lewisburg; J. C. Arnett, Rowlesburg; B. S. Brake, Clarksburg; J. M. Brand, Chester; Martha Jane Coyner, Harrisville; Allen M. Dyer, Jr., Pine Grove; Vernon L. Dyer, Petersburg; Earl L. Fisher, Gassaway; O. M. Harper, Clendenin; J. C. Huffman, Buckhannon; Guy R. Post, Fairmont; and Clark K. Sleeth, Morgantown.

Syphilis

N. H. Dyer, Charleston, Chairman; David F. Bell, Jr., Bluefield; Paul V. Graham, Wheeling; Paul L. McCuskey, Parkersburg; C. Y. Moser, Kingwood; A. L. Osterman, Wheeling; Frank M. Peck and Bruce H. Pollock, Huntington; and Thomas L. Thomas, Wheeling.

Tuberculosis

Ralph H. Nestmann, Charleston, Chairman; Charles E. Andrews, Morgantown; Deane F. Brooke, Beckley; J. Russell Cook, Huntington; William L. Cooke, Charleston; N. Allen Dyer and Robert W. Neilson, Bluefield; James H. Walker, Charleston; and M. L. White, Jr., Huntington.

SPECIAL COMMITTEES

AMA-ERF

Earl S. Phillips, Wheeling, Chairman; Kenneth J. Allen, Moundsville; William E. Bray, Jr., Huntington; C. Leonard Brown, Pt. Pleasant; Dante Castrodale, Welch; Harry F. Cooper, Beckley; John E. Echols, Richwood; Robert J. Fleming, Morgantown; Weldon Harloe, Princeton; I. M. Kruger, Logan; Charles L. Leonard, Elkins; Karl J. Myers, Philippi; J. Keith Pickens, Clarksburg; C. D. Pruett, Bluefield; and Jack D. Woodrum, Hinton.

Medical-Dental Liaison

Clyde Litton, Charleston, Chairman; Don S. Benson, Moundsville; Ray M. Bobbitt, Huntington; Edgar F. Heiskell, Jr., Morgantown; Newman H. Newhouse, Charleston; and Robert S. Robbins, Wheeling.

Medico-Pharmaceutical Relations

L. Dale Simmons, Clarksburg, Chairman; Andrew E. Amick, Lewisburg; Harold B. Ashworth, Moundsville; Joseph Gilman, Clarksburg; and John I. Markell, Princeton.

Nurses Liaison

W. Fred Richmond, Beckley, Chairman; Vernon L. Dyer, Petersburg; William C. D. McCuskey, Wheeling; William A. Thornhill, Jr., Charleston; Gordon L. Todd, Princeton; Edward J. Van Liere, Morgantown; and A. J. Villani, Welch.

School Health

Leo H. Mynes, Charleston, Chairman; Kenneth D. Bailey, Fairmont; William M. Bruch, Bluefield; Donald M. Burke, Elkins; Thomas G. Folsom, Huntington;

Greenbrier Pictorial

(See Pages 320-321)

(1) Members of the Resolutions Committee are shown following a meeting of the group. Left to right, Drs. Maynard P. Pride of Morgantown, Pat A. Tuckwiller of Charleston, Albert C. Esposito of Huntington, Howard G. Weiler of Wheeling, and C. R. Davisson of Weston.

(2) Dr. and Mrs. L. J. Pace, Dr. George M. Fister and Dr. and Mrs. D. E. Greenelteh are shown greeting guests at the reeeption honoring offieers on Saturday evening, August 25.

(3) Dr. Paul H. Ward of Chicago, left, and Dr. A. Edward Maumenee of Baltimore, right, guest speakers, are shown with Dr. Albert C. Esposito of Huntington.

(4) Drs. James S. Klumpp of Huntington and Frank J. Holroyd of Princeton, left, and AMA Field Representative John W. Pompelli, right, are shown with AMA President Dr. George M. Fister.

(5) Dr. Halvard Wanger of Shepherdstown, eenter, Chairman of the Program Committee, is shown with guest speakers, Dr. James G. Hughes of Memphis, Tennessee, left, and Dr. John W. Hope of Philadelphia.

(6) Dr. William S. Middleton of Washington, left, a guest speaker, with Dr. William E. Gilmore of Parkersburg.

(7) Dr. Frank J. Holroyd of Princeton, left, and Dr. Harold Van Hoose of Man, right, with AMA President Dr. George M. Fister.

(8) Drs. S. Elizabeth McFetridge and Halvard Wanger of Shepherdstown with their sons, Dr. William H. Wanger, left, and H. Alexander Wanger, right, and their wives, Laura and Naney.

(9) Drs. M. D. Reiter of Wheeling and Merle S. Seherr of Charleston, left, shown with Drs. Irving W. Schiller of Boston, William A. Hopkins of Atlanta, and Gustav J. Beek of New York City, speakers at a Symposium on Allergic and Related Diseases.

(10) Drs. William S. Middleton of Washington and Stewart G. Wolf of Oklahoma City, Oklahoma, speakers at the seeond general session on Friday, August 24, with Dr. Thomas H. McGavaek of Martinsburg, the moderator.

Emma Jane Freeman, Charleston; Ralph E. Haynes, Bluefield; Grover C. Hedrick, Jr., Beckley; Warren D. Leslie, Wheeling; and Meryleen B. Smith, Bluefield.

WVU Liaison

George F. Evans, Clarksburg, Chairman; W. Carroll Boggs, Wheeling; D. Sheffer Clark, Huntington; R. U. Drinkard, Wheeling; Carl B. Hall, John W. Hash and John A. B. Holt, Charleston; J. C. Huffman, Buckhannon; Charles L. Leonard, Elkins; J. P. McMullen, Wellsburg; Maynard P. Pride, Morgantown; and L. Dale Simmons, Clarksburg.

Sections and Affiliated Societies Elect Officers for 1962-63

Meetings of sections and affiliated societies and associations of the West Virginia State Medical Association were held during the 95th Annual Meeting at The Greenbrier, August 23-25.

All of the guest speakers on the general scientific program participated actively in the afternoon meetings. The meetings were well attended, especially those for which a scientific program had been arranged.

Sections

The following is a list of officers of sections, societies and affiliated associations who will serve during the coming year:

Orthopedic Surgery: Dr. Lawrance S. Miller, Morgantown, President; Dr. J. Hunter Smith, Welch, Vice President; and Dr. Robert S. Wilson, Clarksburg, Secretary-Treasurer.

W. Va. Radiological Society: Rex Dauphin, Parkersburg, President; Harold I. Amory, Morgantown, Vice President; and Karl J. Myers, Philippi, Secretary-Treasurer.

W. Va. Association of Pathologists: Wilhelm Albrink, Morgantown, President; Peter Ladewig, Charleston, Vice President; and J. Evan Sadler, Huntington, Secretary-Treasurer.

W. Va. Academy of Oph. and Otol.: William K. Marple, Huntington, President; James T. Spencer, Charleston, President Elect; R. Alan Fawcett, Wheeling, Vice President; and Worthy W. McKinney, Beckley, Secretary-Treasurer.

Neurology, Neurosurgery and Psychiatry: James B. Nichols, Charleston, President; C. G. Polan, Huntington, President Elect; and William B. Rossman, Charleston, Secretary-Treasurer.

Surgery: Bernard Zimmermann, Morgantown, President.

Internal Medicine: Ralph H. Nestmann, Charleston, President; and Arnold J. Brody, White Sulphur Springs, Secretary-Treasurer.

Urology: E. Burl Randolph, Clarksburg, President; Donald R. Gilbert, Charleston, Vice President; and Harold N. Kagan, Huntington, Secretary-Treasurer.

W. Va. Pediatric Society: W. D. Leslie, Wheeling, President; K. D. Bailey, Fairmont, Vice President; and Emma Jane Freeman, Charleston, Secretary-Treasurer.

Industrial Medicine and Public Health: George F. Fordham, Jr., Mullens, President; and Virgil J. Dorset, Charleston, Secretary-Treasurer.

Societies

W. Va. State Society of Allergy: W. L. Neal, Huntington, President; Charles L. Leonard, Elkins, Vice President; and Merle S. Scherr, Charleston, Secretary-Treasurer.

W. Va. Society of Anesthesiologists: Harry S. Weeks, Jr., Wheeling, President; Newman H. Newhouse, Charleston, Vice President; and W. H. Rardin, Beckley, Secretary-Treasurer.

W. Va. Ob. and Gyn. Society: Frederick H. Dobbs, Charleston, President; Warren D. Elliott, Beckley, Vice President; and A. J. Villani, Welch, Secretary-Treasurer.

Amendment to By-Laws Adopted By House of Delegates

One amendment to the By-Laws of the West Virginia State Medical Association was adopted by the House of Delegates during the final session on Saturday afternoon, August 25.

The amendment was offered at the first session on Wednesday evening, August 23, by Dr. Richard E. Flood of Weirton, Chairman of the Committee on Constitution and By-Laws.

It relaxes requirements for honorary membership in the State Medical Association, stipulating that only the last five years of the required 15 years membership prior to age 70 must have been as a member of a component society of the State Association.

The amendment is as follows:

(1) Amend Chapter I, Section 5, By-Laws, as follows: Delete the first sentence of the second paragraph and insert in lieu thereof the following:

"Any member of this Association who has attained the age of seventy (70) years and who has been a member in good standing of this or any other state medical association for fifteen (15) years, the last five (5) of which as a member in a component society of this Association, may, upon nomination by his component society, be elected an honorary member of this Association."

New Film Available

A new film entitled "Ligation of the Internal Iliac (Hypogastric) Arteries: A Life-Saving Procedure for Uncontrollable Gynecologic and Obstetric Hemorrhage," is available for showings at meetings of component medical societies.

The 24-minute color film presents a discussion of the anatomy, demonstrations of cadaver anatomy, and actual surgical demonstrations in the operating room. The techniques are discussed as well as the indications both definitive and prophylactic.

The film may be obtained by writing to the Film Library, Armour Pharmaceutical Company, P. O. Box 511, Kankakee, Illinois.

State Health Department Plans Birth Defects Register

A Birth Defects Register, which will involve the collection of voluminous data related to congenital malformations, is to be instituted as a new program of the Division of Maternal and Child Health of the West Virginia Department of Health.

State Director of Health N. H. Dyer, writing in a recent issue of the department's "State of the State's Health," points out that this project "has exciting possibilities and could make a significant contribution to isolating the causes of all birth defects."

This program is being conducted as a part of a special project grant which the Maternal and Child Health Division received during the past fiscal year from the U. S. Children's Bureau. This same grant also made possible the expansion of the current mental retardation program.

About One-Half Reported

Doctor Dyer noted that West Virginia records an average of 700 to 750 stillbirths each year, plus about 250 live births with congenital defects listed on the certificate. Most authorities believe that only about one-half of all birth defects are reported, due to difficulty of diagnosis on delivery. "We could save hundreds of children and eliminate thousands of miscarriages if we could just get precise knowledge with which to work," he said.

"Over the years," Doctor Dyer continued, "we have discovered many factors related to stillbirths and congenital malformations. This information, coupled with better medical care, improved nutrition during pregnancy, immunization and other preventive measures has paid significant dividends." The state's record on stillbirths is impressive, with a decline from 1,166 in 1951 to 665 in 1961 and also a decrease in congenital malformations.

The new Register will call for a three point program. The first step is the notation of each case on records submitted to the Division of Vital Statistics and an immediate follow-through by the public health nurses, in cooperation with the Crippled Children's Service, to insure medical attention as soon as possible. The nurses will make thorough investigations of all cases, utilizing an exhaustive questionnaire. "When sufficient facts are accumulated, they will be correlated with similar findings available from researchers in other parts of the nation and analyzed for possible avenues of further investigation," Doctor Dyer said.

Methods of Financing

The Director of Health also called attention to the methods of financing health programs in West Virginia.

During fiscal 1962, expenditures totaled $6,500,011, of which $3,985,537 came from federal funds, $1,058,634 from state appropriations, and $1,455,840 from county, municipal and other sources.

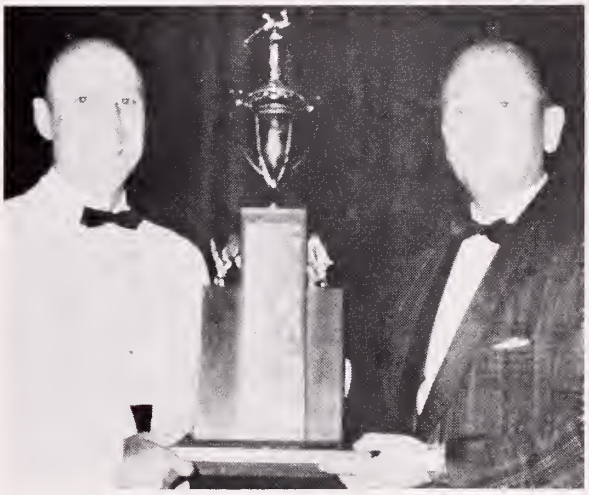
Hill-Burton funds represented the largest item of the total received from federal sources, but Doctor Dyer commented that "even so, the balance of $957,222 was 48.6 per cent of the entire amount available for support of all other programs administered by this department."

"Actually," he said, "most state and federal funds find their way to local health units in the form of direct financial aid or for direct and consultative services." Over 42 per cent of the 1962 appropriation by the Legislature was apportioned among county health units for direct aid.

Dr. Joseph T. Mallamo Wins Medical Golf Tournament

Dr. Joseph T. Mallamo of Fairmont won the medical golf tournament held in connection with the 95th Annual Meeting of the State Medical Association at The Greenbrier in White Sulphur Springs, August 23-25.

Doctor Mallamo shot a 73 to win his sixth title in seven years and his first leg on the beautiful trophy



Dr. Joseph A. Smith of Dunbar, right, presents the championship golf trophy to Dr. Joseph T. Mallamo of Fairmont, winner of the medical golf tournament held in connection with the annual meeting at The Greenbrier.

offered by the Hospital and Physicians Supply Company of Charleston. He retired a previous championship trophy in 1960.

His closest rivals for low gross honors were Drs. George R. Callender, Jr., and R. A. Crawford, both of Charleston, who shot 78's. Other low scorers were Drs. William C. Morgan, Jr., of Charleston, 80, and George A. Curry of Morgantown, Joseph A. Smith of Dunbar, and Kenneth E. Owen of Marietta, Ohio, 81.

Drs. William E. Gilmore of Parkersburg and James A. Heckman of Huntington tied for low net honors. Other winners in this category were Lt. Gen. Leonard D. Heaton of Washington, D. C., and Drs. Jack Leckie of Huntington, R. R. Brown of Romney, and Francis L. Coffey of Huntington.

Winners in the various categories of the tournament received useful golfing equipment purchased from funds realized from a $5 registration fee. Prizes were awarded at the Presidential Dinner on Saturday evening, August 25.

Dr. Joseph A. Smith of Dunbar served as chairman of the golf committee.

Mrs. Howard G. Weiler of Wheeling New Auxiliary President

Mrs. Howard G. Weiler of Wheeling was installed as President of the Woman's Auxiliary to the West Virginia State Medical Association during the 38th Annual Meeting at The Greenbrier in White Sulphur Springs, August 23-25. She succeeds Mrs. Vernon L. Dyer of Petersburg.

Nearly 200 wives of physicians were registered during the three-day meeting which was held concurrently with the 95th Annual Meeting of the West Virginia State Medical Association.

Mrs. Howard G. Weiler

Mrs. Weiler and the other newly elected officers were installed at the second general session on Friday morning, August 24, by Mrs. William G. Thuss of Birmingham, Alabama, president of the Woman's Auxiliary to the American Medical Association.

Mrs. Thuss delivered the keynote address at the opening session on Thursday morning. Another distinguished speaker was Mrs. Roy A. Douglass of Huntingdon, Tennessee, president of the Woman's Auxiliary to the Southern Medical Association, who addressed the second general session on Friday morning.

Address by John W. Pompelli

Another honor guest who appeared on the Friday morning program was John W. Pompelli of Chicago, AMA Field Representative, who delivered an interesting address entitled "You are One-Half of One Doctor's Team."

Auxiliary members joined their husbands and families in Governor's Hall for the Association's opening exercises on Thursday morning. The first speaker was Lt. Gen. Leonard D. Heaton, Surgeon General of the Army, who presented an address on "The Role of Army Medical Research in National Defense."

Mrs. Pat A. Tuckwiller of Charleston was named president elect and will be installed as president during the 1963 meeting at The Greenbrier next August 22-24. Other new officers for the coming year are as follows:

First vice president, Mrs. L. Dale Simmons of Clarksburg; second vice president, Mrs. A. J. Villani, Welch; third vice president, Mrs. Andrew J. Weaver, Clarksburg; fourth vice president, Mrs. W. V. Wilkerson, Whitesville; treasurer, Mrs. Grover C. Hedrick, Jr., Beckley; recording secretary, Mrs. J. A. B. Holt, Charleston; corresponding secretary, Mrs. Chesterfield J. Holley, Wheeling; and parliamentarian, Mrs. J. E. Spargo, Jr., of Wheeling.

Mrs. Weiler has named the following chairmen of committees to serve during her term of office:

Standing Committees

Archives and History, Mrs. D. E. Greeneltch, Wheeling; Finance, Mrs. Harry E. Beard, Huntington; Legislation, Mrs. George A. Curry, Morgantown; Community Services, Mrs. Elmore M. Clubb, Jr., Weirton; Membership, Mrs. Pat A. Tuckwiller of Charleston; Press and Publicity, Mrs. Francis J. Gaydosh, Wheeling; Program, Mrs. William R. Rice, Dunbar; Editor, State News Bulletin, Mrs. R. O. Strauch, Wheeling; Circulation Manager, News Bulletin, Mrs. David W. Palmer, Wheeling; By-Laws and Handbook, Mrs. William A. Thornhill, Jr., Charleston; Southern Medical Councilor, Mrs. Vernon L. Dyer, Petersburg; National Bulletin, Mrs. John H. Trotter, Morgantown; Members-at-Large, Mrs. Hu C. Myers, Philippi; and American Medical Association Education and Research Foundation, Mrs. Robert T. Bandi, Wheeling.

Special Committees

Convention, Mrs. W. E. Ackermann, Wheeling, and Assistant, Mrs. Chesterfield J. Holley, Wheeling; Necrology, Mrs. Robert R. Pittman, Marlinton; Health Careers. Mrs. C. L. Terlizzi, Huntington; Safety-Civil Defense, Mrs. Herbert N. Shanes, Grafton; Mental Health, Mrs. A. C. Chandler, Charleston; Nutrition and Rural Health, Mrs. Lynwood D. Zinn, Clarksburg; Liaison to Woman's Auxiliary, Student American Medical Association, Mrs. Clark K. Sleeth, Morgantown; and Resolutions, Mrs. J. C. Huffman, Buckhannon.

Executive Board

Two past presidents of the Auxiliary, Mrs. Clark K. Sleeth of Morgantown and Mrs. Vernon L. Dyer of

Mrs. Vernon L. Dyer of Petersburg, left, immediate past president of the State Auxiliary, and Mrs. L. T. Veach, also of Petersburg, right, are shown with national and regional officers who attended the 38th Annual Convention at The Greenbrier. They are Mrs. William G. Thuss of Birmingham Alabama, president of the AMA Auxiliary, and Mrs. Roy A Douglass of Huntingdon, Tennessee, president of the Southern Medical Association's Auxiliary.

Mrs. Grover C. Hedrick, Jr., of Beckley, right, presented awards at The Greenbrier for Auxiliary participation in the American Medical Association Education and Research Foundation program. The recipients were Kanawha County AMA-ERF chairman Mrs. James T. Spencer of Charleston, left, for the largest contribution; Potomac Valley president Mrs. Harry F. Coffman of Keyser, doubling last year's gift; and Fayette County president Mrs. Joe N. Jarrett of Oak Hill, the largest per capita contribution.

Petersburg, have been appointed by Mrs. Weiler to serve as members of the Executive Board.

Advisory Board

Dr. L. J. Pace of Princeton, president of the West Virginia State Medical Association, has named the following Advisory Board to the Woman's Auxiliary:

Dr. D. E. Greeneltch, Wheeling; Dr. J. C. Huffman, Buckhannon; Dr. Clark K. Sleeth, Morgantown; Dr. Vernon L. Dyer, Petersburg; and Dr. Howard G. Weiler, Wheeling.

New President Native of Vermont

Mrs. Howard G. Weiler, the new president, is a native of Fair Haven, Vermont, and a graduate of the School of Nursing at Massachusetts General Hospital in Boston.

Dr. and Mrs. Weiler have three children and five grandchildren. Dr. Robert R. Weiler, the eldest of two sons, is specializing in orthopedic surgery at Allegheny General Hospital in Pittsburgh.

Mrs. Weiler has been active in the Woman's Auxiliary to the Ohio County Medical Society for several years. She served two years as State Health Careers Chairman and State Convention Chairman. She enjoys golf, skating and travel.

Post-Convention Conference

Mrs. Weiler presided at the post-convention conference and meeting of the Executive Board on Saturday morning, August 25. Plans for the coming year were discussed and the members of the Advisory Board to the Auxiliary were introduced.

Dr. George M. Fister of Ogden, Utah, President of the American Medical Association, spoke briefly before the group.

Entertainment Program

A capacity crowd composed of members and guests attended a luncheon and fashion show which was held in the Crystal Dining Room on Friday. The new fall fashions were shown by Alanson's of The Greenbrier.

A large crowd also attended the Friday night presentation by the Barter Players of Abingdon, Virginia, in Chesapeake Hall. The musical comedy "Fantasticks" was presented through the courtesy of the Potomac Valley Medical Society.

Program Committees

Mrs. L. T. Veach of Petersburg served as convention chairman and she was assisted by Mrs. Thomas E. Bess of Keyser. Mrs. Weiler appointed Mrs. W. E. Ackermann of Wheeling as the 1963 convention chairman, and Mrs. Chesterfield J. Holley, also of Wheeling, as co-chairman.

Mrs. Gilmore Golf Winner

Mrs. William E. Gilmore of Parkersburg won the annual golf tournament. Her closest rivals for low gross honors were Mrs. Tracy N. Spencer, Jr., of South Charleston, and Mrs. W. E. McNamara of Wheeling. Mrs. J. M. Scott of Madison had the low net score followed by Mrs. James E. McClung of Richwood. Mrs. George A. Curry of Morgantown and Mrs. Howard J. Maxwell of Petersburg tied for third. Mrs. W. H. Evans of Youngstown, Ohio, was the low scorer among the out-of-state entrants.

Newly elected officers of the Woman's Auxiliary to the West Virginia State Medical Association are shown following their election at The Greenbrier. They are, left to right, Mrs. Pat A. Tuckwiller of Charleston, president elect; Mrs. A. J. Villani of Welch, second vice president; Mrs. L. Dale Simmons of Clarksburg, first vice president; Mrs. Andrew J. Weaver, Clarksburg, third vice president; Mrs. William V. Wilkerson of Whitesville, fourth vice president; Mrs. Grover C. Hedrick, Jr., of Beckley, treasurer; and Mrs. Howard G. Weiler of Wheeling, president.

ACP President Will Be Speaker At Greenbrier Meeting

Dr. Franklin M. Hanger of Staunton, Virginia, president of the American College of Physicians, will be among the guest speakers at a regional meeting of that organization at The Greenbrier in White Sulphur Springs, November 2-3.

Franklin M. Hanger, M. D.

Doctor Hanger will be the speaker at a banquet which will be held on Friday evening, November 2. He was installed as president of the ACP at the Annual Meeting in Philadelphia in April.

Physicians from West Virginia, Western Pennsylvania and Ohio will attend the two-day meeting. Dr. R. U. Drinkard of Wheeling, Governor of the West Virginia Chapter, ACP, said a meeting for members of the American Society of Internal Medicine from these three states will be held in conjunction with the regional meeting.

Dr. Edmund B. Flink of Morgantown, Professor and Head of the Department of Medicine at the WVU School of Medicine, is Chairman of the Program Committee.

Dr. Arnold J. Brody of White Sulphur Springs is chairman of the Committee on Arrangements. Room accommodations may be obtained by writing to the Reservation Manager at The Greenbrier.

Vocational Rehabilitation Division Receives National Recognition

West Virginia has again ranked first in the nation in the proportion of its population rehabilitated during the past fiscal year to a productive and satisfying life.

Announcement of the achievement by the State Rehabilitation Division was made in Washington by the Department of Health, Education and Welfare.

During the fiscal year that ended June 30, 1962, West Virginia helped 201 disabled people in each 100,000 of its population to achieve rehabilitation. This is the highest mark ever set by a state and is almost four times as great as the national average of 55 per 100,000 population.

New Leaflet on Drug Safety

A new leaflet, "Safety of Prescription Drugs," has been published by the Pharmaceutical Manufacturers Association and is available to physicians for distribution to their patients.

Copies of the leaflet may be obtained by writing Dr. Robert J. Benford, Director of Medical Relations, Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D. C.

MCV Alumni Assn. Meeting Held in Charleston

A reorganization meeting of the Kanawha Valley Chapter of the Alumni Association of the Medical College of Virginia was held recently in Charleston.

Thirty-five alumni were present at the meeting called by Dr. Carl B. Hall of Charleston. Also in attendance at the meeting were Dr. Peter N. Pastore, president of the Alumni Association; Dr. Kinloch Nelson, chairman of the Department of Continuing Education; and Miss Minnie M. Franck, executive secretary of the Association.

Dr. John W. Hash was elected president of the Chapter for the coming year. Named president elect was Dr. Joseph A. Smith of Dunbar, and secretary-treasurer, Dr. Catherine E. Stoeckel of Charleston.

Dr. J. M. Brand Named Member Of WVU Athletic Council

Dr. J. M. Brand of Chester has been named to a two-year term as an alumnus member of the West Virginia University Athletic Council.

Doctor Brand, a former WVU track and cross country star who for 30 years held the University 880-yard run record, succeeds Dr. Jack T. Gocke of Clarksburg on the seven-member council which administers the intercollegiate athletics program.

ACCP Course in Chicago, Oct. 22-26

The 17th annual postgraduate course in Clinical Cardiopulmonary Physiology, sponsored by the American College of Chest Physicians, will be held at the Knickerbocker Hotel in Chicago, October 22-26.

The registration fee is $75 for ACCP members and $100 for non-members. Further information may be obtained by writing the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Fracture Association Meeting

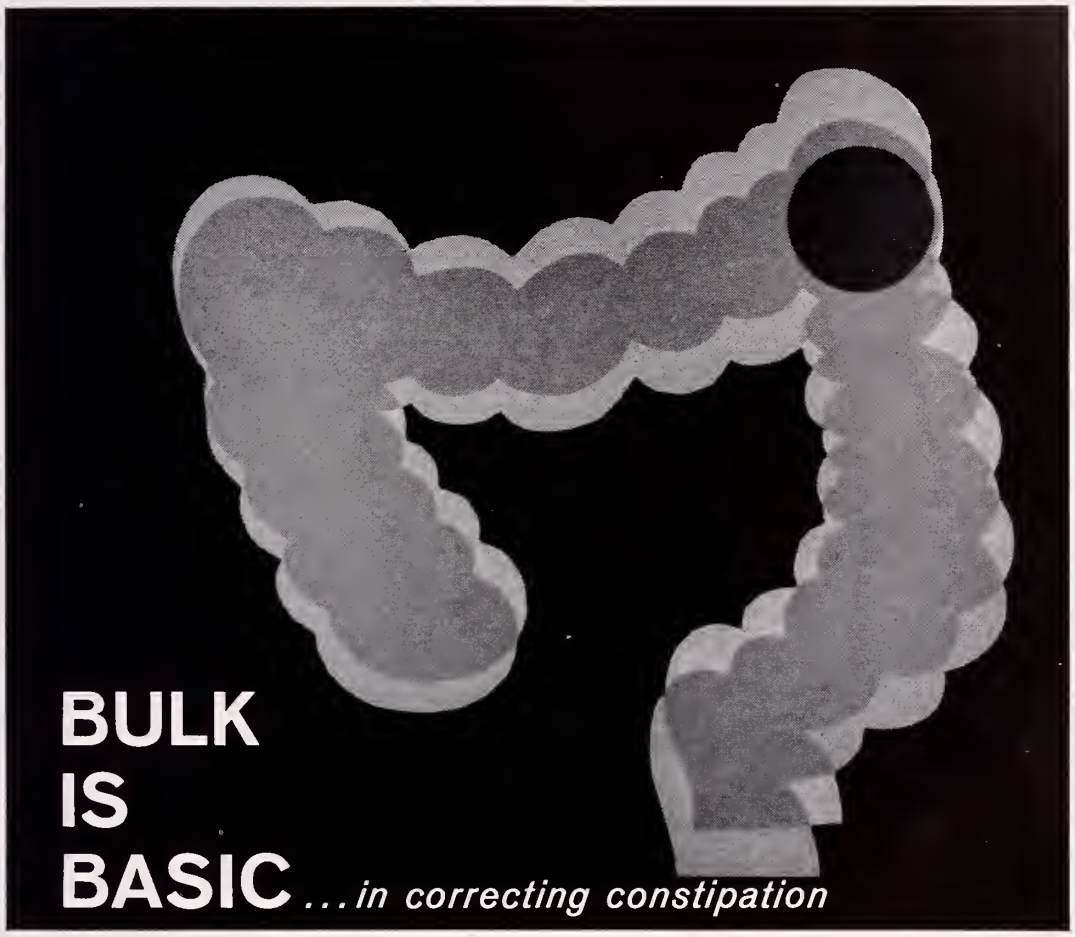
The 23rd Annual Meeting of the American Fracture Association will be held at the Huntington-Sheraton Hotel in Pasadena, California, October 20-25. The meeting will feature an instructional course in fractures and there also will be round table luncheons.

Further information may be obtained by writing Dr. H. W. Wellmerling, 610 Griesheim Building, Bloomington, Illinois.

Medical Meetings, 1962

The following is a partial list of national, state and district medical meetings scheduled for 1962:

Oct. 1-4—Interstate PG Assembly, Chicago.
Oct. 4—Rural Health Conference, Morgantown.
Oct. 4-6—Congress on Mental Illness, Chicago.
Oct. 9-11—W. Va. TB and Health Assn., Beckley.
Oct. 15-19—ACS Clinical Congress, Atlantic City.
Oct. 22-23—American Cancer Soc., New York.
Nov. 2-4—ACP Regional Meeting, White Sul. Springs.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 24-25—ACCP, Ambassador Hotel, Los Angeles.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.



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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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Research in the Service of Medicine

WVU Medical Center
—News—

• **Compiled from material furnished by Howard Lewis, Administrative Assistant to the Vice President, West Virginia University Medical Center, Morgantown, West Virginia.**

ONLY 30 of the four-year medical schools in the United States will receive more direct monetary support this year from the AMA's Educational and Research Foundation than the West Virginia University School of Medicine.

Dr. Clark K. Sleeth, Dean of the School of Medicine, announced recently that WVU received $14,374.64 from the Foundation. This is part of the $1,303,161.10 contributed by physicians to medical schools in 1961.

Dean Sleeth said the money will be used for various purposes, primarily for needs that could not be seen in advance or were not budgeted through regular state appropriations. This includes equipment and supplies, travel to national and international meetings and money for short research projects to prove the feasibility of long term support by foundations and governmental agencies.

Associate Professor of Pharmacology Named

Dr. Thomas D. Darby, a native of South Carolina and a specialist in cardiovascular pharmacology, has joined the School of Medicine faculty as associate professor of pharmacology.

He received a B. S. degree in chemistry in 1952 at The Citadel in Charleston, South Carolina. The new faculty member earned his master of science degree in pharmacology in 1954 and the Ph.D. in the same field in 1957, both at the Medical College of South Carolina.

Doctor Darby remained at the Medical College of South Carolina as a faculty member through 1960. He was a member of the faculty at Tulane University in New Orleans last year.

Dr. Gerwig Named Professor of Surgery

Dr. Walter H. Gerwig, Jr., of Clarksburg, has been elevated from associate professor to professor of surgery at the West Virginia University School of Medicine. He also is head of the Department of Surgery at the Veterans Hospital in Clarksburg.

Doctor Gerwig is a native of Parkersburg and prior to his appointment to the staff at the VA Hospital in 1958, he was associate clinical professor of surgery at the George Washington University School of Medicine. He also served as consultant in surgery at Walter Reed Army Hospital in Washington, D. C.

He attended the two-year School of Medicine at West Virginia University and received his M. D. degree from the University of Maryland School of Medicine in 1935. Doctor Gerwig is certified by the American Board of Surgery and is a member of the American College of Surgeons, American Surgical Association, the Halsted Society, the Association for Colon Surgery, Harrison County Medical Society, West Virginia State Medical Association and American Medical Association.

Two Instructors Appointed

Dr. Roy L. Butcher, a native of Reedy in Roane County, has been named as an instructor in obstetrics and gynecology at the School of Medicine. He is a graduate of WVU and received his Ph.D. in June from Iowa State University. His graduate work was in animal reproduction.

Dr. Stanley H. Stolar of Montreal, Canada, has been named an instructor in anesthesiology. He received his M. D. degree from Dalhousie University in Halifax, Nova Scotia and has just completed a three-year diploma course in anesthesiology at McGill University in Montreal.

Receives $1,000 Scholarship

Erskine M. Caperton, Jr., of Mount Hope, a second-year student at the School of Medicine, has received a $1,000 Pfizer Laboratories Scholarship.

Caperton was one of four students in the School of Medicine to make the Registrar's Honor Roll with a straight-A average during the second semester of the 1961-62 academic year. He ranked third in a class of 60 first-year students.

Receives NIH Research Grant

Dr. Thomas D. Darby, associate professor of pharmacology at the School of Medicine, has been awarded a $74,520 grant from the National Institutes of Health for a five-year study into measurements of heart muscle tone.

Doctor Darby did extensive research in cardiac dynamics at Tulane University prior to joining the WVU faculty in July. During the next five years he will undertake his research in special laboratories, using test animals under highly controlled conditions. Information from such experiments has found practical use in the treatment of shock and other diseases involving the heart.

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Thomas C. Camp, Ph. D.
Artie L. Sturgeon, Ph. D.

William D. Keck, M. D.
Edward W. Gamble, III, M. D.
J. William Giesen, M. D.
Internist (Consultant)

Don Phillips
Administrator

AFFILIATED CLINICS

Bluefield Mental Health Center
525 Bland St., Bluefield, W. Va.
David M. Wayne, M. D.
Phone:325-9159

Charleston Mental Health Center
1119 Virginia St., E., Charleston, W. Va.
Phone: 344-3578

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.
Malcolm G. MacAulay, M. D.
Phone: 253-8397

Norton Mental Health Clinic
Norton Community Hospital, Norton, Va.
Pierce D. Nelson, M. D.
Phone: 218, Ext. 55 and 56

The Month in Washington

• From the Washington Office of the American Medical Association.

A special advisory committee reported to the Public Health Service that the occurrence of 12 cases of polio among persons who had taken 38 million doses of oral vaccine did not provide any ground for questioning the safety of the live-virus vaccine. Reporting on the study by the advisory committee, Dr. Luther L. Terry, Surgeon General of the PHS, said:

"Following administration of more than 38 million doses of oral vaccine, only 12 cases, outside of the epidemic areas, including five from Oregon, have been reported which had their onset of illness within 30 days of vaccination.

"Although the number was very small in relation to the number given vaccine and the diagnosis in certain of these cases seems questionable, I decided to call together members of my advisory committee to examine in detail the diagnosis, laboratory studies, and epidemiological circumstances relating to each of the cases.

"The group met on two occasions, on August 9 and 16, and after careful consideration of the facts, concluded that it was not possible to establish that the vaccine virus caused any of the cases. The advisers emphasized that polio viruses, as well as other viruses, are frequently present in the community and that it can be anticipated that occasionally poliomyelitis or illnesses simulating it may occur following vaccination programs. Illness and injury completely unrelated to polio and naturally occurring cases of polio have continued and, no doubt, will continue to be attributed to the vaccines. Furthermore, it is well known and recognized that any effective medication administered to millions of persons will cause or appear to cause a number of side effects.

"The committee, in summary, urged the continuation of present and projected programs of immunization looking toward the final elimination of the disease."

As of August 11, the approximate midpoint of the polio season, 274 cases of paralytic polio had been reported. The total, of which 129 cases were in Texas where outbreaks of Type 1 had been occurring, was the same as for a comparable period last year.

Life Expectancy

Life expectancy at birth reached an estimated 70.2 years in the United States in 1961, according to the Public Health Service. The estimate was based on a 10 per cent sample of death records received by the National Vital Statistics Division from all the 50 states.

Deaths totaled about 1,702,000 in 1961—a rate of 9.3 per 1,000 population, only slightly higher than the record low rate of 9.2 for 1954.

Five of 10 leading causes of death showed sharp rate declines as compared with 1960. The declines were large enough to make it improbable that they were produced by normal fluctuations due to sampling. The five were vascular lesions; accidents; influenza and pneumonia, except of newborn; general arteriosclerosis, and diabetes mellitus.

The infant mortality rate of 25.3 per 1,000 live births set a record low, about two per cent under the previous low of 25.7 recorded in 1960.

Comparing Apples to Oranges

Recent statements that citizens of some foreign countries are healthier than Americans was disputed emphatically by the American Medical Association. The AMA statement was prompted by a paper presented at the recent annual meeting of the American Sociological Association in Washington. The paper said that the United States is not as "healthy" as Sweden and England.

"This is like trying to compare apples to oranges," F. J. L. Blasingame, M. D., the AMA's Executive Vice President, said.

"There have been accounts that comparisons of a nation's overall health can be made on the basis of life expectancy—that the people of Sweden and Britain are healthier because they live longer on the average than Americans.

"This proves nothing, for what you are actually comparing are differences in the makeup of populations. Both of these nations have small, stable, homogeneous populations, whereas that of the United States is a vast mixing from practically every conceivable corner of the globe, including all nationalities and races.

"What you can prove statistically is that a person of Swedish descent in Minnesota lives longer than a Swede in Sweden, and that Mexicans apparently live longer in New Mexico than they do in Mexico.

"The death rate from automobile accidents is much higher in the United States than in any European country because a large percentage of the population own cars. This is a matter of economics and not medicine. Yet auto fatalities are a large factor in reducing this nation's life expectancy."

Doctor Blasingame also pointed out the economic aspect of Americans living at a faster pace, consuming more expensive, fatty foods and dying of heart attacks with much more frequency.

Annual Reports*

Insurance Committee

You will be contacted shortly regarding the new American Medical Association Health and Accident Plan. This plan is a supplementary plan to our program and is an excellent one. There is a waiting period of one year after disability before benefits are available. Your Committee suggests that you consider buying this insurance.

Your Committee has been disappointed in not being able to implement the Trust and Retirement Fund Program which was authorized by our Council in 1961. The Trust Department of the Charleston National Bank in Charleston, West Virginia, was chosen as the Trustee of the program. When it appeared that all legal problems had been solved, we were informed by the Securities Exchange Commission that our program had to be registered with that body.

Two other state associations which had similar programs in force were also notified of this action. One group simply discontinued any addition to their fund. The other group organized a separate brokerage unit through a local broker of that state. This approach does not appeal to our Committee.

The cost of registration by the Securities Exchange Commission is estimated to run from $30,000-$50,000. This, in our opinion, is prohibitive. Your Committee, however, has learned that the retirement program can be handled under the jurisdiction of the Federal Reserve System. The cost of developing such a program is estimated to run between $3,000-$5,000. The Charleston National Bank of Charleston, West Virginia, has agreed to underwrite this expense, so it appears that within the next year we should have our retirement plan implemented. Your Committee will keep you informed.

Our State Association Group Insurance Program continues to operate efficiently and effectively for the benefit of our members. Participation is at an all time high. Approximately 70 per cent of our members (over 800) currently participate in the program.

Our Group Program has been in operation since 1948 and our members are afforded insurance in a firmly-established and time-tested program. Plans available are actuarially sound and based upon proven underwriting experience. The continued strong support of our membership is attributed to a well-earned reputation for progress and dependability—both in coverage and service.

A complete program of Disability Insurance is provided for our members. A broad selection of plans enables a member to select the pattern of coverage needed to fit his individual requirements. Coverages now available include:

- Monthly Income Protection
- Office Overhead Insurance
- Family Catastrophe Hospitalization
- Accidental Death Insurance

All coverages are designed to contemplate serious long-term disabilities.

Service continues to be the keystone of our program. All policy services, including the processing and payment of claims, are provided by our Resident Administrator. He maintains a qualified, experienced staff whose members travel the state and are available for personal consultation wherever their services are needed. Our long experience in the operation of our Group proves beyond any doubt the fundamental advantage of this "on the ground" service to our members. Adequate service is a basic requirement of any product. To a seriously disabled person it is often an absolute necessity.

Respectfully submitted,
Charles A. Hoffman, M. D.,
Chairman

Necrology Committee

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

Aug. 9	Benjamin F. Moyers	Bridgewater, Va.
Aug. 18	George Lewis Pence	Hinton
Aug. 30	Hugh Graves Thompson	Charleston
Sept. 9	Clavius Clyde Coffindaffer	Clarksburg
Sept. 28	Loami L. Aultz	Huntington
Oct. 2	George Washington Wyatt	Dryfork
Oct. 14	William M. Sheppe	Wheeling
Oct. 23	Hugh Duncan McPherson	Ravenswood
Oct. 29	Liskie Jay Moore	Huntington
Nov. 1	Simon B. Chandler	La Mesa, Calif.
Nov. 7	Richard Owen O'Dell	St. Albans
Nov. 17	William Edward Echols	Richwood
Dec. 5	Donald Monroe Post	Morgantown
Dec. 10	John Pierpont Helmick	Fairmont
Dec. 14	Ritchie Alexander Ireland	Charleston
Dec. 20	Bayard Lee Liggett	Mill Creek
Dec. 24	Russell Smith Coffindaffer	Shinnston
Jan. 1	Elmer E. Myers	Philippi
Jan. 25	Everett Walker	Baltimore, Md.
Jan. 28	Walter E. Vest	Huntington
Jan. 28	Uriah Vermillion	Athens
Feb. 19	J. Frank Williams, Jr.	Clarksburg
Feb. 21	Aubrey W. Armentrout	Martinsburg
Mar. 24	Arthur E. Bays	Montgomery
Apr. 1	Donzel D. Chapman	Weston
Apr. 1	E. E. Watson	Kingwood
Apr. 7	Alvin Goshorn Bowles	Beckley
Apr. 11	M. W. McGehee	Huntington
May 4	V. L. Glover	Martinsburg
May 6	W. W. Currence	South Charleston
June 15	J. B. Dodrill	Webster Springs
June 16	Charles A. Zeller	Charleston
June 17	E. Ross Allen	Clarksburg
July 2	Harry Cobliner	Charleston
July 10	Fred J. Potter	Parkersburg
July 19	Robert S. Widmeyer	Parkersburg
July 20	S. W. Tretheway	Wheeling
July 31	L. M. Halloran	Beckley
Aug. 3	W. C. Slusher	Miami, Florida
Aug. 18	Roger E. Clapham	Martinsburg

Respectfully submitted,
Andrew J. Weaver, M. D.,
Chairman

*Other annual reports were published in the August, 1962, issue of The Journal.

Resolutions

Three resolutions offered at the first session of the House of Delegates on Wednesday evening, August 22, 1962, were referred to the Committee on Resolutions for study and report back, with recommendations, at the final session on Saturday afternoon, August 25.

Dr. Albert C. Esposito of Huntington, the chairman, presided at a meeting of the Committee which was held on Thursday afternoon, August 23.

Resolution No. 1 was approved by the Committee and Resolutions No. 2 and No. 3 were amended. The resolutions, adopted by the House, follow:

Resolution No. 1. Enactment of a Medical Examiner's System in West Virginia—By the Kanawha Medical Society.

WHEREAS, The West Virginia State Medical Association, with the cooperation of the West Virginia Association of Pathologists and other interested groups, sponsored a bill in the 1961 session of the Legislature providing for the creation and maintenance of a Medical Examiner's System in West Virginia; and

WHEREAS, Although the spokesmen for the group favoring passage of the measure were accorded respectful hearings by the Judiciary Committees in the Senate and House, and the bill was subsequently passed by the House during the final days of the session with no action taken by the Senate, and

WHEREAS, The members of the West Virginia State Medical Association still feel strongly that the establishment of such a system would be in the best interests of the citizens of West Virginia:

NOW, THEREFORE, BE IT RESOLVED, That the House of Delegates of the West Virginia State Medical Association again approve the establishment of a Medical Examiner's System in West Virginia and urge the Council and the Legislative Committee to have the bill reintroduced in and seek its passage at the regular session of the Legislature in 1963, and

BE IT FURTHER RESOLVED, That every effort be made by the Council to enlist the support of members of the Legislature and other interested professional and business groups for the passage of the bill.

* * * *

Resolution No. 2. Regarding Autopsy Consent—By the West Virginia Chapter of the American Academy of General Practice.

WHEREAS, There is now no law covering who may sign for autopsy consent, and

WHEREAS, Many autopsies are lost due to lack of responsible person to sign the permit, and

WHEREAS, It is necessary for a hospital to have 25 per cent autopsies to total number of deaths to retain accreditation, and

WHEREAS, It is necessary that every effort be made to legally cover all actions of those persons involved in obtaining and performing an autopsy:

NOW, THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association present to the State Legislature at the regular session in 1963 a bill to clarify the responsibilities of all persons involved in obtaining and performing an autopsy, and

BE IT FURTHER RESOLVED, That an order of Consent Authority for Autopsy be established, with the order of Consent Authority as follows:

(1) Surviving spouse of deceased.

(2) If there be no surviving spouse, then any child of deceased over the age of 21 years.

(3) If there be no surviving spouse nor any child of deceased over the age of 21 years, then the mother or father of deceased.

(4) If there be no surviving spouse nor any child of deceased over the age of 21 years nor mother or father of deceased, then any brother or sister of deceased over the age of 21 years.

(5) If there be no surviving spouse nor any child of deceased over the age of 21 years nor mother or father of deceased, nor brother or sister of deceased over the age of 21 years, then any grandchild of deceased over the age of 21 years.

(6) If there be no surviving spouse nor any child of deceased over the age of 21 years nor mother or father, nor brother or sister over the age of 21 years, nor grandchild of deceased over the age of 21 years, then any descendant of the mother or father of deceased over the age of 21 years.

(7) If there be no surviving spouse nor any child of deceased over the age of 21 years, nor mother or father, nor brother or sister over the age of 21 years, nor grandchild of deceased over the age of 21 years, nor any descendant of the mother or father of deceased over the age of 21 years, then the previously appointed or acting fiduciary of the estate of the deceased.

(8) If there be none of the above, that the body of the deceased be embalmed pursuant to instructions issued by the Department of Anatomy of the West Virginia University School of Medicine and transported to the West Virginia University Medical Center in Morgantown.

* * * *

Resolution No. 3. Health Care of Our Senior Citizens—By the Council.

WHEREAS, It is generally recognized that, (1) health care of our senior citizens, and the means of providing same, is now a moot question; (2) the present national administration, and some state administrations, abetted and supported by certain labor leaders and professional social service workers, have made the issue a political football, with millions of potential votes at stake, (3) the very future political and economic freedoms of our citizens are endangered by this determined effort to deliver our national and individual welfare under central government control, and (4) as physicians and as voters, we should assume the full responsibilities as well as the privileges of citizenship;

THEREFORE, BE IT RESOLVED, That, (1) The House of Delegates of the West Virginia State Medical Association hereby reaffirms its previous statements as to the preservation of individual freedom and initiative in a sincere effort to provide voluntary and adequate medical care to every citizen young or old; (2) it is our firm conviction that those citizens who are truly indigent shall be served without cost to themselves; (3) every other senior citizen shall have available a program of prepaid voluntary medical and health care with individual contribution toward the costs thereof in direct proportion to his or her economic status; (4) there shall be no compulsion on any person to participate in such a program; (5) the members of this Association are urged to participate actively as individuals in any election of state or national officials whose duties may be associated with the legislation or operation of any program for health care of the aged; (6) we as physicians shall continue

to use whatever upright and ethical means are at hand to let our opinions be known to our fellow-citizens and to those in national and state offices; and, (7) it is our considered opinion that our members should act as individuals in supporting the American Medical Political Action Committee, with active participation in political-economic activities of that organization in their communities and congressional districts.

* * * *

Report of Resolutions Committee

The Chairman of the Committee, Dr. Albert C. Esposito, submitted his report to the House of Delegates at the final session on Saturday afternoon, August 25. The report follows:

Your Committee on Resolutions has carefully considered the resolutions offered before the first session of the House of Delegates on Wednesday evening, August 22, 1962.

Several members of the Association appeared at a meeting of the Committee held on Thursday afternoon, August 23, 1962, and discussed in detail the resolutions pending before the Committee. The cooperation of these physicians has been most helpful to the Committee in reaching decisions, and we express appreciation to those who took time to attend the open hearing.

Your Committee assures the members of the House of Delegates that the one and only consideration that has guided the Committee in its deliberations has been the criteria as to whether each of the resolutions, as well as resolutions offered last year, were or would be to the best interests of the entire medical profession in West Virginia.

Again, we wish to thank the members of the West Virginia State Medical Association who appeared before the Committee at the open hearing on August 23, 1962.

Your chairman personally expresses his gratitude to the members of the Committee for the patience, enthusiasm, wisdom and valuable time devoted to the study of the resolutions.

In addition to your Chairman, the members of the Committee participating were Drs. C. R. Davisson, Weston; Maynard P. Pride, Morgantown; Pat A. Tuckwiller, Charleston; Howard G. Weiler, Wheeling; and William H. Lively, secretary ex officio, and Jerry Gould, Executive Assistant.

Courtesy Resolutions Adopted

Dr. James S. Klumpp asked and obtained the unanimous consent of the House for the introduction of three courtesy resolutions. The resolutions which follow were adopted unanimously:

Resolution No. 4. Distribution of Morning Newspaper During Convention.

WHEREAS, For several years, our members have been greeted each morning with a complimentary copy of The Charleston Gazette bearing a "Good Morning, Doctor" slip; and,

WHEREAS, This is a fitting start for a pleasant day at The Greenbrier and constitutes a very welcome traditional gesture:

THEREFORE, BE IT RESOLVED by the House of Delegates of the West Virginia State Medical Association, That our Executive Secretary be instructed to transmit our formal thanks to the Hospital and Physicians Supply Company for the traditional courtesy.

* * * *

Resolution No. 5. Appreciation for Cooperation of Personnel at The Greenbrier.

WHEREAS, Our three-day interlude at The Greenbrier during the course of the annual meeting has come to be of increasing significance in the scientific and social calendars of our members and their families; and,

WHEREAS, One important aspect of this delightful season is occasioned by the luxurious environment and superior services afforded to our members and guests by the Hotel personnel:

THEREFORE, BE IT RESOLVED by the House of Delegates of the West Virginia State Medical Association, That our Executive Secretary be directed to transmit a formal expression of our thanks and gratitude to the management and operating personnel of The Greenbrier Hotel for their efforts in providing this pleasurable environment.

* * * *

Resolution No. 6. Coverage by News Media of All Sessions at The Convention.

WHEREAS, In recognition of the fact that certain events which occur during the Annual Meeting of this Association are in large part of interest to those we serve, and that adequate communication of these matters are of transcendant importance in the light of present history:

THEREFORE, BE IT RESOLVED by the House of Delegates of the West Virginia State Medical Association, That our Executive Secretary be directed to transmit a formal expression of thanks to the United Press International, the Associated Press, the daily newspapers, in particular the Charleston Daily Mail and The Charleston Gazette, to radio and television facilities and to all other providers of public information for the clarity and understandable manner in which our activities are brought to public attention.

Resolution No. 7. Commending Mr. John Pompelli, Field Representative of the American Medical Association.

WHEREAS, Ever since the activation of Kerr-Mills legislation in West Virginia and the concomitant economic and political activities in opposition to Social Security coverage of aged health care, the medical profession in this State has had access to the valued advice and the organizational acumen of one John Pompelli, Field Representative of the American Medical Association; and

WHEREAS, During this trying period he has been indefatigable in the efforts made to crystallize sentiment against the enactment of such compulsory legislation and for the continuance of professional freedoms associated with our responsibilities to our senior citizens; and

WHEREAS, Our parent organization has seen fit to reward Mr. Pompelli with a change in duty status to another area of the United States, a change which will be a great loss to all of us:

THEREFORE, BE IT RESOLVED by the House of Delegates of the West Virginia State Medical Association, That our Executive Secretary be directed to transmit a formal expression of our gratitude to Mr. Pompelli; and,

BE IT FURTHER RESOLVED, That a copy of this resolution shall be sent to Mr. Aubrey D. Gates, Director of the Field Service Division of the American Medical Association.

Obituaries

THOMAS W. MOORE, M. D.

Dr. Thomas W. Moore, 95, of Huntington, a past president of the West Virginia State Medical Association and the Southern Medical Association, died on August 28 in that city. Doctor Moore was born on October 4, 1866, in Catlettsburg, Kentucky. He was graduated from the Cincinnati College of Pharmacy and for more than five years was chief pharmacist at the National Military Home Hospital in Dayton, Ohio.

Thomas W. Moore, M. D.

He resigned there to study medicine at the Medico-Chirurgical College of Philadelphia, now the Postgraduate Medical School of the University of Pennsylvania, receiving his M. D. degree there in 1893.

Doctor Moore engaged in general practice for several years at Everett, Pennsylvania, before doing postgraduate work in eye, ear, nose and throat at Knapp's Ophthalmological and Aural Institute in New York City.

Upon finishing his specialty studies in 1897, he located in Huntington and proceeded to organize the Cabell County Medical Society with eight charter members. He was elected its first president and for eight years thereafter was its secretary. He was elected secretary of the State Medical Association in 1906 and held that position until 1909 when he was elected president, serving during 1910.

In 1914, Doctor Moore became a member of the Southern Medical Association. He served on its Council for 11 years, one term on its board of trustees, as chairman of the Section on Ophthalmology and Otolaryngology in 1917, as president in 1929, and as official representative to the Cuban profession on a tour of Cuba which followed the annual meeting in Miami that year.

Doctor Moore was the recipient of many honors from the medical profession. In 1960, he was awarded a plaque by the West Virginia Chapter of the American College of Surgeons for his many years of distinguished service in surgery.

In 1958, he became the second man to receive the Southern Medical Association's Distinguished Service Award. The presentation was made at the Association's Annual Meeting in New Orleans.

Doctor Moore always was active in continuing medical education. He had postgraduate training in Vienna and was certified in both ophthalmology and otolaryngology.

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Doctor Moore was an honorary life member of the Cabell County Medical Society, West Virginia State Medical Association, Southern Medical Association and the American Medical Association.

He is survived by a son, Thomas W. Moore, Jr., of Huntington; a brother, Charles V. Moore of Gallipolis, Ohio; and a sister, Mrs. Herman Gherman of Marion, Ohio.

* * * *

ROGER E. CLAPHAM, M. D.

Dr. Roger E. Clapham of Martinsburg, 70, died on August 18 at his home in that city.

Doctor Clapham was a native of Martinsburg. He attended Shepherd State College and received his B. S. degree in 1921 from West Virginia University. He taught in public schools two years before entering the University of Cincinnati College of Medicine where he received his M. D. degree in 1927.

He served an internship at St. Elizabeth Hospital in Covington, Kentucky, and opened his practice at Martinsburg in 1927. He retired in 1953 due to illness.

Doctor Clapham served in the United States Army in World War I and in World War II was a Lieutenant Commander in the Medical Corps of the United States Navy. He was an honorary member of the Eastern Panhandle Medical Society, West Virginia State Medical Association, Southern Medical Association and American Medical Association.

In addition to his widow, he is survived by a son, Thomas M. Clapham of Pittsburgh, Pennsylvania; one brother, Franklin Clapham of Vanclevesville, and three grandchildren.

* * * *

C. C. JARVIS, M. D.

Dr. C. C. Jarvis, 86, of Clarksburg, died on August 28 at a hospital in that city.

A native of Harrison County, Doctor Jarvis was born on December 19, 1875, near Shinnston. He received his M. D. degree from Jefferson Medical College in Philadelphia in 1902 and interned at Allegheny General Hospital in Pittsburgh.

His first practice was in general medicine in Pittsburgh. Following postgraduate work in eye, ear, nose and throat in Philadelphia and New York, Doctor Jarvis opened his practice in Clarksburg in 1907.

Active in the Harrison County Medical Society, Doctor Jarvis served as secretary for many years. He was an honorary life member of that society, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by two sons, James M. Jarvis of Clarksburg, and Dr. Shiras M. Jarvis of Eureka, California; and two daughters, Mrs. Norman S. Elliott of Richmond, Virginia, and Mrs. Margaret Villers of Pasadena, California.

* * * *

W. C. SLUSHER, M. D.

Dr. W. C. Slusher, 82, formerly of Bluefield, died on August 3 at Miami, Florida.

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A native of Floyd County, Virginia, Doctor Slusher was actively engaged in practice at Bluefield for 40 years before his retirement in 1955. He was graduated from William & Mary College and received his M. D. degree from the University of The South Medical Department in 1903.

Doctor Slusher opened his practice in 1904 in Floyd County, Virginia, and moved to Bluefield in 1916. During World War I he served in the Medical Corps of the United States Army.

He was a former member and president of the Mercer County Medical Society, and a former member of the West Virginia State Medical Association and the American Medical Association.

Doctor Slusher is survived by three daughters, Mrs. K. George Cox of Miami, Florida, Mrs. Charles Crowley of Rochester, New York, and Mrs. Richard Morris of Birmingham, Michigan; one son, W. C. Slusher, Jr., of Silver Springs, Maryland, and 14 grandchildren.

Fitness

What is fitness? Fitness I think is positive health, not just the absence of disease. That is one of the health factors that we in the medical profession have been rather negligent about. We are pretty good now in diagnosis, and in treatment, both medical and surgical. But that's not good enough. We've got to have positive health; and undoubtedly our way of life must have an influence on this positive health—not just on the presence or absence of disease.

How can we promote middle age fitness? In the first place, we can continue to hold the gains already made and we can increase our control of infections, including the common cold. When I was hardly able to speak at the opening of the European Congress of Cardiology in Rome early last September, I begged those famous cardiologists to do something, or stimulate somebody to do something, about the common cold as well as about heart disease.

Secondly, we can sharply decrease accidents, especially on the road. There are a lot of middle aged crippled people because of avoidable accidents at home or in industry or especially on the road.

Thirdly, we can reduce the heavy burden of mental disease. But these are, of course, general problems. We can all take some role in them.

There are many other challenges such as arthritis and crippling metabolic diseases, cancer, hypertension, and finally, the particular subject I want to speak of, namely serious atherosclerosis at too early an age. However, I wouldn't want to abolish coronary atherosclerosis. It is a very good way to terminate life if it can be very sudden, a matter of seconds, at an old enough age after a life free of all illness. That's what we want to aim at, I think. In other words, we might prefer 100 per cent mortality from cardiovascular disease under ideal circumstances.

Most important, we want to establish in youth, especially in the 20's, habits of positive health which will without question greatly improve fitness, not only in middle age but in old age, too. Many of the problems of old age will melt away if we can improve middle age fitness.—Paul Dudley White, M. D., in Arizona Medicine.

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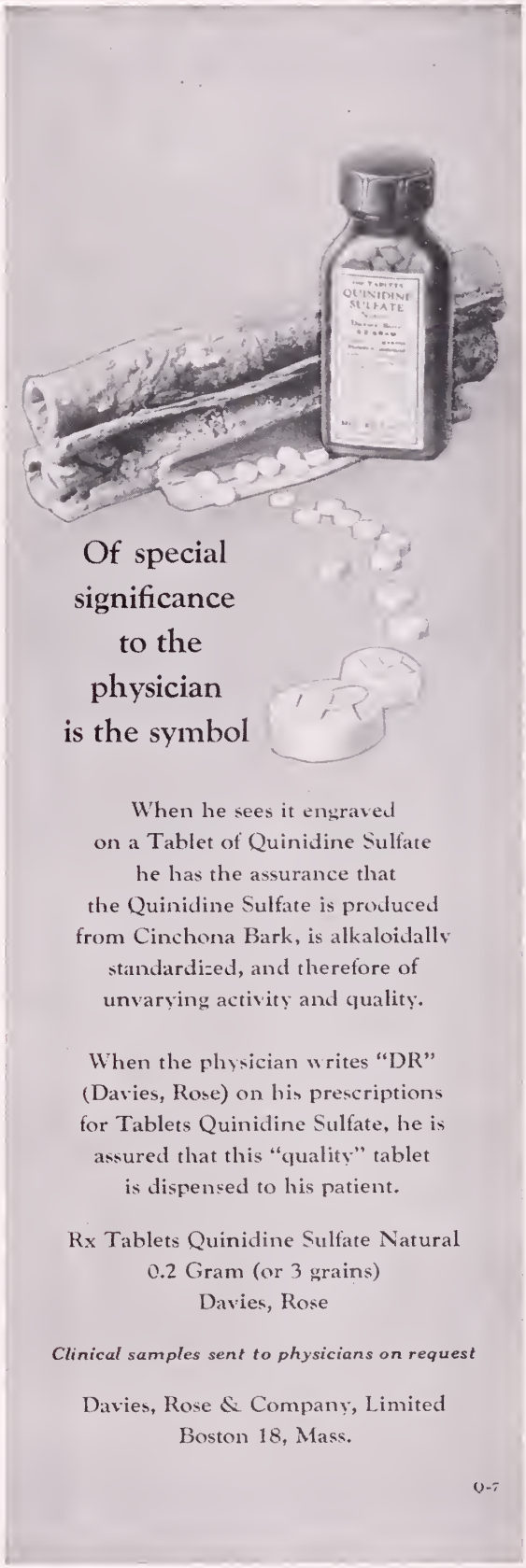

County Societies

HARRISON

Dr. Albert V. Ferguson, Jr., of Pittsburgh, delivered an address on "Athletic Injuries" at the regular monthly meeting of the Harrison County Medical Society, which was held at the Stonewall Jackson Hotel in Clarksburg on September 6.

Doctor Ferguson, Professor of Orthopedic Surgery at the University of Pittsburgh School of Medicine and team physician for the Pittsburgh Pirates baseball club, stressed the need for competent instructors and good equipment for the best protection of the athlete.

Dr. Andrew J. Weaver of Clarksburg, the president, presided at the dinner meeting which also was attended by Harrison County school administrators, coaches and teachers.

Wages and Hospital Costs

The sharp rise in hospital costs over recent years is due largely to higher wages and the scientific breakthrough in medicine. Neither surgeons' fees nor "hotel"-type services such as television sets, telephones and choice of entrée at mealtime have contributed substantially to the increase, says the Health Insurance Institute.

Citing statistics of the American Hospital Association, the Institute said higher payrolls represented nearly two-thirds of the increase in costs in U.S. general hospitals since 1956.

Between 1956 and 1960, average hospital costs per patient day increased by $8.08, from $24.15 to $32.23. Labor costs accounted for 65 per cent of the rise, representing $20.08 of the total average cost in 1960 as against only $14.85 in 1956.

Advances in scientific medicine have resulted in a rising investment in hospital equipment and treatment facilities. Equipment like cobalt, kidney and heart lung machines, along with improved facilities, raised the value of ownings of the nation's non-governmental hospitals by 44 per cent over the 1956-60 span. Assets climbed from $7.5 billion to $10.9 billion.

By comparison, surgeons' fees, as measured by the consumer price index, were up only 11 per cent.

A study of 54 general hospitals in the New York area showed that "hotel"-type services, which had accounted for half of the average per diem costs in hospitals in 1947-49, dropped to 28 per cent in 1960. Hospital services, including such items as medical and surgical supplies, pharmacy, operating rooms and physical therapy, now account for the largest segment of the hospital dollar.—Survey of Health Economics.

It is very difficult for the average person to realize that friction with his spouse is based not so much upon minor contemporary provocations as upon the earlier frustrations and resentments of his childhood.—Karl Menninger.

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1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.

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'Eskatrol' *Spansule* capsules should be used with caution in the presence of severe hypertension, advanced cardiovascular disease, or extreme excitability.

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Never before in history, within one generation, has man's technological progress outdistanced so much of his experience. More scientific advance has occurred within the lifetime of a 15-year-old boy than in the previous fifteen hundred years. For 99 per cent of the time man has been on earth no one ever traveled faster than a horse. Yet, within one lifetime, man went from horse and buggy to the space age.

If the destiny of the medical profession is to keep pace with this fantastic march of science, physicians must begin now to consider the transcending problem that will one day beset them, namely, making a "night call" in space. Whether today's physicians will be bypassed by progress at 40 or be pioneers of progress at 70, depends on their reaction to the challenge of change, the great challenge we are all facing today in our shrinking world as we boldly enter the space age. —U. S. Senator John C. Stennis, in the Journal of the Mississippi State Medical Association.

Industrial Health Conference

The 1963 American Industrial Health Conference will be held in Washington, D. C., March 18-21, 1963. The Conference is comprised of the annual meetings of the Industrial Medical Association and the American Association of Industrial Nurses.

Further information may be obtained by writing the American Industrial Health Conference, 55 East Washington Street, Chicago 2, Illinois.

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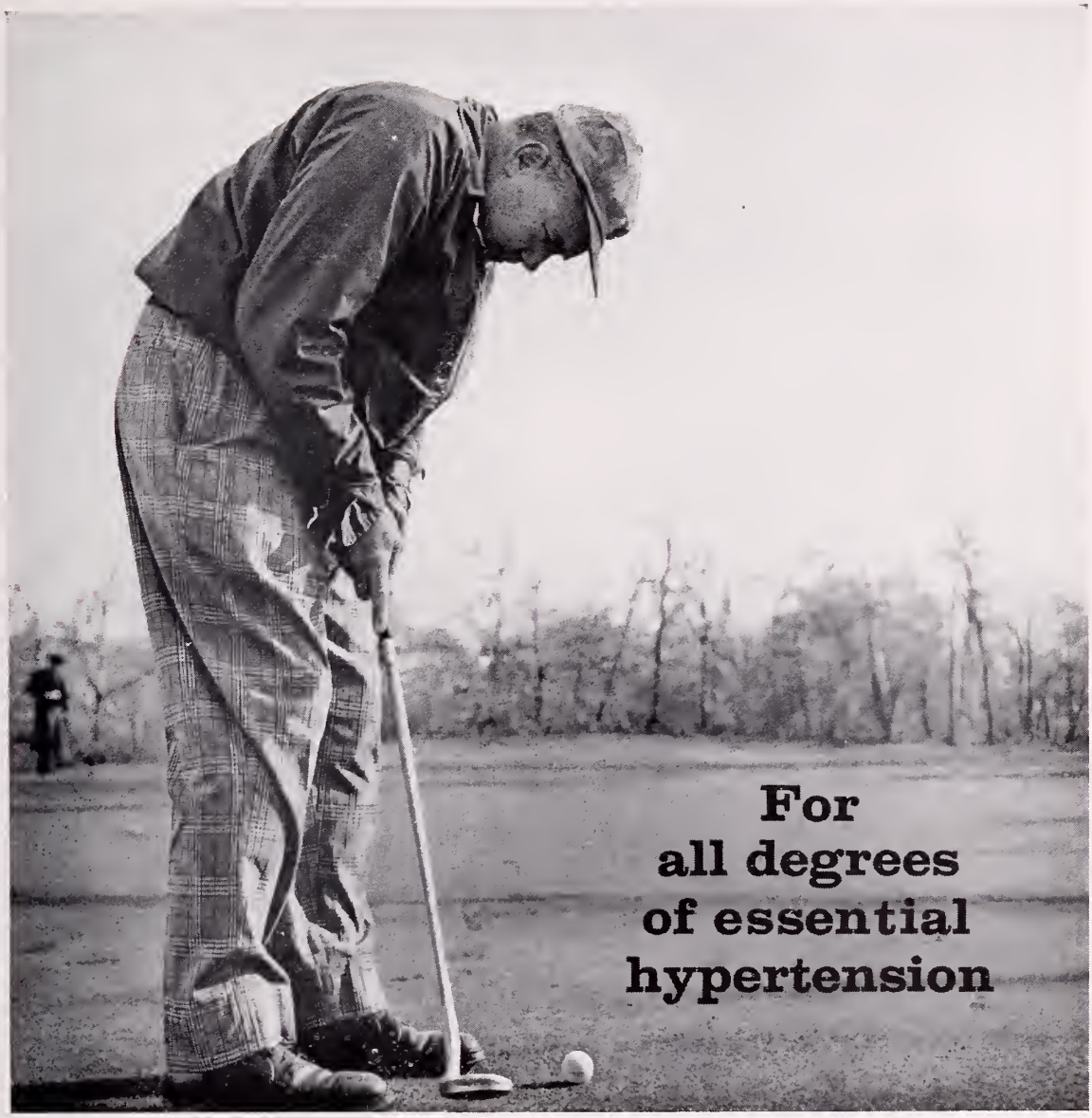

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†Hutchison J. C.: Current Therap. Res. *2*:487 (Oct.) 1960.

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McDOWELL

The Woman's Auxiliary to the McDowell County Medical Society resumed its regular monthly meetings on September 12 at the home of Dr. and Mrs. Arthur Allen Carr in War.

Mrs. George L. Fischer of Welch, the new president, presided over the meeting. The immediate past president, Mrs. Hendrick A. Bracey of Welch, was presented with a gift of silver from the Auxiliary.

Final plans were made for the annual Crippled Children's Bridge Party to be held in October. The 1961 party provided $400 for the Crippled Children's Fund.—Mrs. F. L. Johnston, Secretary.

Best Drugs Are Yet to Come

There is no question that in the United States, it has been the pharmaceutical companies who have done the major research work in the discovery and the initial testing of the drugs we call the tranquilizers. I think we owe a great debt of gratitude to these companies for this research job.

I have the impression that when this whole new concept of the treatment of mental illness by drugs was begun, had the control of it, and particularly the "efficacy" of these drugs been a matter of jurisdiction by the federal government, my guess is we would not have had them. I think it was the competitive research activities among the drug houses that led to these—and fortunately for all of us in this field, still continues.

My conviction is that the best of the drugs is probably yet to come, and the chances are good that it will come out of the research, the competitive research if you will, among the drug houses.—William C. Menninger, M. D., to Senate Subcommittee on Antitrust and Monopoly.

Blue Shield Payments

The 74 Blue Shield Plans located in the United States and Canada paid out more than $231,500,000 for care rendered to members during the first quarter of 1962, the National Association of Blue Shield Plans reported recently.

The increasing role being played by Blue Shield Plans in helping almost 50 million members meet the cost of medical-surgical care is evidenced by the interesting fact that the 74 Plans paid out more in the first three months of 1962 than in all of 1952.

Books Received

PEDIATRIC DIAGNOSIS.—By Morris Green, M. D., Associate Professor of Pediatrics, Indiana University School of Medicine; and Julius B. Richmond, M. D., Professor and Chairman of the Department of Pediatrics, State University of New York College of Medicine, Syracuse. Pp. 541. Second Edition. W. B. Saunders Company: Philadelphia and London. 1962. Price $13.00.

* * * *

THE RELUCTANT SURGEON, A biography of John Hunter—By John Kobler. Pp. 439 (Paperback). Doubleday and Company, 575 Madison Avenue, New York 22, New York. 1962. Price $1.45.

* * * *

PEDIATRICS—By L. Emmett Holt, Jr., M. D., Professor of Pediatrics, New York University School of Medicine; Rustin McIntosh, M. D., Carpentier Professor Emeritus of Pediatrics, Columbia University; and Henry L. Barnett, M. D., Professor and Chairman, Department of Pediatrics, Albert Einstein College of Medicine, Yeshiva University. Pp 1395, with numerous illustrations. Appleton-Century-Crofts, Inc., 34 West 33rd Street, New York 1, N. Y. 1962, Thirteenth Edition. Price $18.00.

* * * *

TEXTBOOK OF OPHTHALMOLOGY—By Francis Heed Adler, M. D., Emeritus Professor of Ophthalmology, University of Pennsylvania Medical School; Consulting Surgeon, Wills Eye, Philadelphia General and Children's Hospitals of Philadelphia. Pp. 560 with numerous illustrations. W. B. Saunders Company: Philadelphia and London. 1962. Seventh Edition. Price $9.00.

* * * *

FINANCING MEDICAL CARE—Edited by Helmut Schoeck. Caxton Printers, Ltd., Caldwell, Idaho.

* * * *

BETWEEN US WOMEN: A Woman Doctor's Handbook on Pregnancy and Birth—By Dr. Laura E. Weber. Pp. 153. Doubleday and Company, 575 Madison Avenue, New York, New York. 1962. Price $1.95.

New Saunders Books

W. B. Saunders Company features the following recent books in their full-page advertisement appearing on page vii in this issue:

Parsons and Sommers—"Gynecology." A useful new guide to management of gynecologic disease—parallels the growth and aging patterns of women covering the disorders accompanying each stage of the life cycle.

Davidsohn and Wells—"Todd-Sanford Clinical Diagnosis by Laboratory Methods." Explicit guidance on how to perform every possible clinical test—what to do, when and how to do it, and how to interpret your results.

Wolff—"Electrocardiography." Help in understanding and evaluating electrocardiograms in terms of clinical medicine—without relying on memorization of examples.

ENZYMES AND DRUG ACTION—J. L. Mongar, Ph.D., Editor for the Co-ordinating Committee for Symposia on Drug Action, Ciba Foundation Symposium. Pp. 556, with 90 illustrations. Little, Brown and Company, Boston, Massachusetts. 1962. Price $12.50.

* * * *

ESSENTIALS OF PEDIATRIC PSYCHIATRY—By Ruben Meyer, M. D., Associate Professor of Pediatrics, Wayne State University College of Medicine; Morton Levitt, Ph.D., Professor of Psychology in Psychiatry and Assistant Dean, Wayne State University College of Medicine; Mordecai L. Falick, M. D., Associate Professor of Psychiatry, Wayne State University College of Medicine; and Ben O. Rubenstein, Ph.D., Associate Professor of Psychiatry, Wayne State University College of Medicine. Pp. 208. Appleton-Century-Crofts, 34 West 33rd Street, New York 1, N. Y. 1962. Price $6.00.

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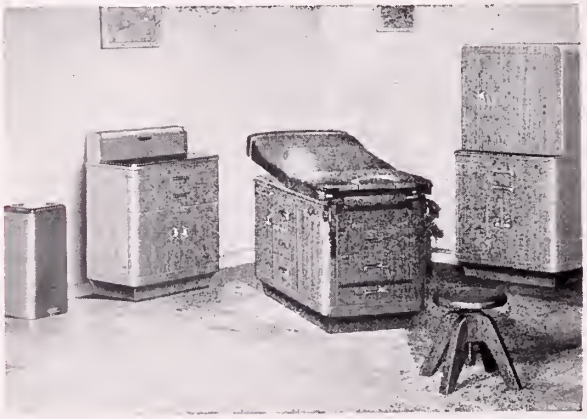

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The WEST VIRGINIA Medical Journal

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Published manthly by the West Virginia State Medical Associatian under the directian af the Publicatian Cammittee. Original articles are accepted an canditian that they are contributed solely to the Journal.

The Publication Committee is nat responsible far the authenticity af apinian or statements made by authars ar in cammunications submitted to this Jaurnal far publicatian. The authar ar communicant shall be held entirely responsible.

Entered as secand-class matter January 1, 1926, at the past affice at Charlestan, West Virginia, under the act of March 3, 1879.

Subscriptian, $3.50 per year; 50¢ per single capy. Advertising rates furnished an request. Address all cammunications ta Business Manager, West Virginia Medical Jaurnal, Bax 1031, Charlestan 24, West Virginia. Phane 346-0551.

Member 1962

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The West Virginia Medical Journal

November, 1962 Vol. 58, No. 11

Empty the Ivory Tower*

George M. Fister, M. D.

I am honored and happy to be here in the Mountain State for the 95th Annual Meeting of my friends in the West Virginia State Medical Association. As one who holds your group in warm respect, I extend my personal greetings. As President of the American Medical Association, I bring the best wishes of 186,000 of your colleagues who *share* that respect.

Much good has come to American medicine from West Virginia. Doctors everywhere are proud of your magnificent new School of Medicine and Medical Center at the University. We are proud, too, that your State has produced such great humanitarians as our late and good friend, Dr. Walter E. Vest. He will be missed by all who were fortunate to work with him in the many activities in which he so whole-heartedly took part. And who could count those who will miss him most—those thousands whose lives were saved or prolonged by the kindness and ability of Doctor Vest? He was a man to remember because he was a citizen of his times.

Awareness of Our Duties

I am happy to say that an awareness of our duties as members of a great country seems to be much a part of medicine in West Virginia. You know better than I how many doctors and their wives took part only recently in medicine's fight to preserve its rights against socialistic curtailments. It was an amazingly large number, and you are to be congratulated for doing a job of public education which was among the best in the nation.

As I appear here today before the House of Delegates, it is to ask that you impress on your membership that we are a long way from *finished* with our campaign. We must implore those who did such a fine job to continue. We must implore even harder those who sat back. We must make them realize how very vital is the voice of every citizen in being heard and making our wishes known to those whom we have appointed to serve our needs.

Our present status was well put to us by one of the fine speakers at the meeting of State Presidents in Chicago in June. The words came from Ernest L. Wilkinson, President of Brigham Young University:

"Whether you medical doctors and other loyal Americans will defeat the King-Anderson bill," Doctor Wilkinson said, "will depend upon whether you will be able to generate political support in your various states of sufficient magnitude to let your Senators and Congressmen know that such a bill must not pass. You cannot rely upon defeating it in the House committee. If it is defeated there, it will raise its ugly head elsewhere. Nowhere is it as true as with legislation that eternal vigilance is the price of liberty. To defeat the present bill, or its counterpart, will require continuous political action on your part. You cannot return to your homes and practices and forget about the destiny of your profession and country."

We must realize that we, as physicians and citizens, are in a battle for survival. Ignoring it

The Author

- **George M. Fister, M. D., Ogden, Utah, President, American Medical Association.**

*Presented before the second session of the House of Delegates during the 95th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 25, 1962.

will not make it go away. If we are to survive, every physician must do his part.

We have been warned by President Kennedy that he will make the King-Anderson legislation a political pawn in the fall elections. If we do not consider ourselves forewarned and do not counter, with logic and truth, the tragic whimsies that will pour from campaign platforms, then we are failing our fellow Americans of all ages.

We are failing the elderly who would be handed this "political placebo" and we fail the young who will pay for it . . . and pay . . . and pay!

Since the mid-July vote in the Senate, newspapers all over the land have re-emphasized that health care for the aged should not be a football of partisan politics. Many of them have pointed out that the 21 Democratic Senators who voted against the Social Security health care plan make up virtually one-third of the Democratic party's 64 Senate members—not just the so-called "handful" described by President Kennedy.

Moreover, the House Ways and Means Committee, dominated by the majority party in the House of Representatives, held long hearings on this issue last year and has steadfastly refused to approve the Administration measure.

In short, this issue is and should be a non-partisan, non-political question. It is a matter of principles and approaches which go beyond the ballot box and the rewards of political office.

The Chicago Sun-Times put it this way shortly after the Senate vote:

"When it has had time for sober reflection, we hope the administration will have a clearer view of this defeat than was indicated by the President's hasty reaction. There is enough doubt about the wisdom of a new system of medical care through Social Security to warrant extended study and debate."

Careful Study Required

Proper decisions, both by Congress and the American people, require careful study not only of specific proposals but also of general background. And when those decisions will affect the good of the patient as well as the ability of the doctor to serve him, then the doctor must know the background and the ramifications of the question, and be vocal and active in expressing his views.

A prominent lawyer in one of our Midwest states reports that in his many contacts with state and local medical societies, he is often asked why the medical profession is so often on the receiving end of misunderstanding and political opportunism. Unfortunately, he says that his answer must be that, by and large, the individual physician does not interest himself in anything except the practice of medicine! He does not want to be bothered with anything except medicine.

We as physicians can understand this attitude. We work hard and we undergo many demands on our time. We often resent the intrusion of anything which takes us away from our patients. We often lack the time to read our medical journals, much less newsletters and reports on legislation and medical economics.

But, as many of West Virginia's active doctors and their wives have so well shown, every physician must realize that the future of medicine will be decided by your elected representatives in Congress and your state legislature.

West Virginia medicine made a fine turnout. But it isn't enough. Nowhere is it enough to have even one member of the state or local society indifferent to the need for his knowledge and his wholehearted participation in citizenship. All of us must be year-round citizens, taking an interest in the politics of our city, county, state and nation. To be informed and incapable of action is almost worthless. To be ready to act but uninformed *is* worthless.

Four Points of Knowledge

There are four points of knowledge and action we should keep in mind:

1. Most professional politicians are inherently decent people. Many would like to do a better job, and they would do so if the general public showed a more positive interest in government and gave them year-round support.

2. The vast majority of civil servants are honest and are trying to give the taxpayer a full return on his tax dollar.

3. Politics will improve as the moral and intellectual tone of our whole society improves. We cannot ignore those who place temptation, financial or otherwise, in the path of a politician. The person who buys or influences political favor, motivated only by selfish interest, is just as guilty as the one who provides that favor.

4. Something can be done by all of us. One answer to bad politics is not less but more and better politics, in which the citizen plays an effective role.

Importance of One Vote

How important is one uneducated or reluctant voter who stays home from the polls? How

powerful is one voter who knows the issue and votes as he sees correct?:

At least three Presidents of the United States were put into office by the margin of a single vote in the Electoral College or in the House of Representatives. Five of our states were admitted to the Union by a single vote. And in a Munich beer hall in 1923, one vote cast by Adolph Hitler gave him leadership of the Nazi party.

Any doctor worth the name would argue that he has a moral obligation to practice medicine to the best of his ability. Then it follows that no doctor can be indifferent to the danger of legislation which will hinder that practice. And there is no surer way to lose one's rights and lose the battle than through indifference which permits the federal government to take over.

James Madison put it this way: "I believe there are more instances of the abridgment of the freedom of the people by gradual and silent encroachment of those in power than by violent and sudden usurpations."

And Thomas Jefferson might very well have been talking about the plan to force the taxpayer to shoulder the cost of unnecessary medical expenses through social security when he said:

"To preserve our independence, we must not let our rulers load us with perpetual debt. We must make our choice between economy and liberty, or profusion and servitude. If we can prevent the government from wasting the labors of the people, under the pretense of caring for them, they will be happy."

Mr. Jefferson might have put it another way. He could have used those tender lines:

"Often the statesman and the saint,
Think they're doing good—but ain't!"

And if the statesman isn't doing good, it is up to you and me as citizens to let him know it, to demand that he respect the wishes of an enlightened majority, or it is up to us to replace him at election time. A failure to demand quality and integrity will result in an oversupply of mediocrity and expedience.

Such a failure—viewed in the light of the perilous problems facing our nation in the years and decades ahead—could lead to a shattering of the American way of life and the finest system of medicine in the history of the world!

'White Knight or Black Eye?'

Critics of the drug industry have been numerous and loud. They would have us believe that the typical manufacturer of ethical pharmaceuticals is a latter day Mark Hanna, sporting a dollar mark vest and big cigar, with a cash register in one hand and a bottle of dubious elixir in the other. According to some Washington sources, he makes a usurious profit on the untested, lethal preparations which he is foisting off on a helpless, unsuspecting public. Astonishingly enough, this isn't quite the case.

In 1961, the ethical drug industry spent a record $245.3 million in private funds on research and development, a whopping 8 per cent of sales. This investment in the goal of working itself out of a job amounted to a 13 per cent increase over 1960 and a 500 per cent increase over 1951. The industry employed 13,500 research scientists and technicians, easily leading all other industries in the ratio of scientists to other employees. In total sales of nearly $3 billion, the drug makers did more than their part in stemming the outward flow of gold by selling just under $650 million in foreign trade, an interesting cross-commentary on allegations that you can buy pills cheaper overseas.

The 141 member companies paid $360 million in taxes of which three-fourths was federal income levies. Their profits were not substantially greater than any other aggressively managed business as demonstrated by statements of operation and dividends paid to shareholders. Apart from all this, their contributions to better medical care were enormous. Isn't it about time the drug industry was recognized for its role in uplifting the nation's physical and economic health instead of being portrayed as private enterprise's black eye?—C. P. Crenshaw, M. D., in Journal of the Mississippi State Medical Association.

Gastric Cooling for Upper GI Bleeding: A Simplified Technique and Its Clinical Trial*†

Marsh H. Holt, M. D.

SINCE the introduction, by Wangensteen,[12] in 1958, of gastric cooling in the treatment of upper gastrointestinal bleeding problems, the technique has been applied[5,8,11,12,14,16] in numerous medical centers throughout the country. There has been as yet no publication of results obtained from the use of this procedure other than reports by the original investigators. A critical evaluation of this mode of therapy as well as a review of its application in numerous instances obviously is needed.

Intragastric hypothermia has been employed in procedures such as its use as an adjunct to general hypothermia,[1,6,7] acute experimental pancreatitis[10] and unresponsive hyperpyrexia.[9] Several favorable reports on the use of general hypothermia to lower the blood ammonia level have been published, including those by Welch[15] on laboratory studies and by Clauss[2] on the basis of clinical experience. In instances of hepatic failure with bleeding esophageal varices, the combined effect of controlled hemorrhage and hypothermic limitation of the blood ammonia level has proved beneficial. A further report of the successful use of hypothermia in treating massive upper gastrointestinal bleeding was made recently by Gowen[4] who controlled bleeding in 3 cases by means of general hypothermia alone.

The purpose of this paper is twofold, i. e., to present a small series of cases in which cooling therapy was used for gastrointestinal bleeding and to describe a new gastric cooling unit which was developed to provide an inexpensive, effective and safe apparatus which even the smallest community hospital could afford and use. The study was initiated at the Northwestern University Medical Center and is being continued at the West Virginia University Medical Center.

*Presented before the annual meeting of the West Virginia Chapter, American College of Surgeons, at The Greenbrier in White Sulphur Springs, April 12-14, 1962. This paper was awarded second prize among those presented by residents from hospitals throughout the State.

†Supported in part by Public Health Service Grant No. H-2879.

Submitted to the Publication Committee, May 3, 1962.

*U. S. Stoneware Co., Akron, Ohio

The Author

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Materials and Methods

The cooling unit used was a modification of a previously described model.[8] It has been further developed commercially by Gorman-Rupp Industries, Inc., of Bellville, Ohio. Because of simplicity of design and elimination of a refrigeration unit, the cost is much less than that of currently available devices. The prototype is shown in Figure 1.

An ice chest provides the basic cooling reservoir and structural support. A coiled 20-foot length of ¼ inch thin-walled stainless steel tubing serves as the heat exchange unit. The pump is a small centrifugal air-cooled unit made by the above mentioned concern. Above the pump is a lucite plastic cylinder air trap which is connected by Tygon* plastic tubing to the pump, to a one liter lucite plastic fluid reservoir and receives fluid returning from the intragastric balloon. A thermometer inserted in a plastic T-connector in the inflow or outflow tubing can provide a monitor of the effectiveness of heat exchange both in the stomach and in the ice bath. The operating temperatures average 6° C. inflow and 11° C. in the stomach effluent. The pump, air trap and reservoir are mounted on a metal bar which can be easily detached from its rack on the ice chest and stored within the chest when not in use.

Since the general technique of intragastric cooling and the construction of intragastric balloons have been presented at length elsewhere,[5,8,13,14] the technical description here will be limited to modifications in procedure which are peculiar to this apparatus.

Modifications in Procedure

The cooling unit is filled with water by way of the fluid reservoir with Clamp A open (Figure 1). Air which accumulates during filling is removed from the system by intermittently running the

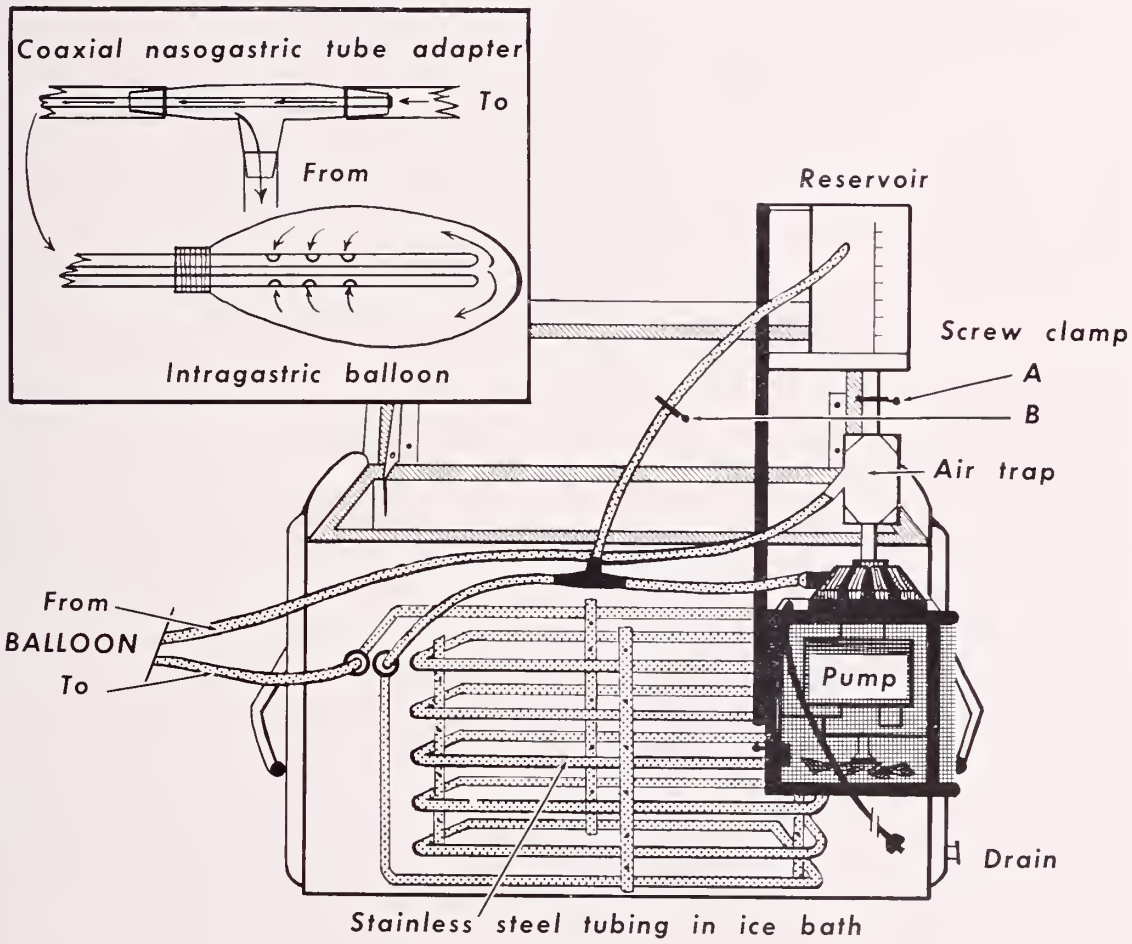
pump and then opening Clamp A to allow air to escape into the reservoir from the trap. Decompression of the balloon is accomplished by shunting fluid into the reservoir with Clamp B open and Clamp A closed. The collapsed balloon is inserted in the stomach by transnasal passage and water, approximately 100 cc., is introduced into the closed system by opening Clamp A while the pump is running. The balloon's location in the stomach is then ascertained by slight traction on the attached nasogastric tubing and when the operator is satisfied that the balloon is not in the esophagus, an additional 300 to 500 cc. of water is added to the system.

When cardio-esophageal cooling is desired, the tubing is withdrawn approximately 10 cm. after the balloon is filled and affixed to the nose with a cube of sponge rubber. This maneuver produces a slight cardio-esophageal tamponade as well as introducing a segment of the balloon into the lower esophagus for cooling. An additional nasogastric tube is passed to lie within the esophagus above the balloon and is maintained on low suction to prevent aspiration of esophageal contents. The exact position of the balloon may be determined by x-ray, following addition of a radiopaque, water soluble iodide solution (100 cc. of diatrizoate 50 per cent) to the circulating fluid. On termination of cooling, Clamp B is released and the balloon is collapsed as fluid is pumped into the reservoir.

Recommended orders for general care during and after the cooling procedure are listed in Table 1.

Results

Intragastric cooling for gastrointestinal hemorrhage has been used in 20 instances on 14 patients. On the five occasions when bleeding has not been completely arrested, it either has ceased temporarily or has decreased in rate. The colon was the site of bleeding in two of the failures, in one of which the patient was in hepatic coma and had a markedly elevated prothrombin time. Fifteen successful applications



ICE CHEST INTRAGASTRIC HYPOTHERMIA UNIT

were made on nine patients. Three of these patients experienced recurrent hemorrhage within two or more days after cessation of cooling, but were found at surgery to have no evidence of recent hemorrhage.

Of the 14 lesions listed in Table 2, there was only one tumor, an ulcerated carcinomatous polyp of the sigmoid colon. The ages of the patients ranged from 27 to 92 years, the average age being 53. Only 3 patients had bled previously, one from varices 3 times before. Bleeding had been present for an average of 2.7 days (1-to-4-day range) before cooling was initiated and 6.8 (3-12 range) units of whole blood had been given with a resulting average hematocrit of 25 volumes per cent (18 per cent to 37 per cent range).

Shock of some degree was present in 8 of the 14 patients on initial cooling. In the twenty applications, an average of 15 hours' cooling was used, with a range of 5 to 38 hours. Though five patients were operated upon after cooling, for the primary cause of bleeding, only two were actively bleeding prior to surgery. Only one of the 7 deaths could be directly attributed to hemorrhage. The fatality from mesenteric thrombosis may have been related to local vasospasm despite a 70 hour interval between the time of termination of the third cooling procedure and the time of death.

Table 1

GENERAL CARE DURING GASTRIC COOLING

1. BP-P-R-T (rectal) q. hour.
2. Irrigate nasogastric tube (inserted prior to cooling) with 30 cc. of iced saline at least q. hour.
3. Change patient's position at least q. hour.
4. Treat shivering or temperature drop with blankets and hot water bottles, groin and axilla. In uncontrolled cases of shivering give phenergan 12.5-25.0 mg. q. 4-6 hours p. r. n.
5. Sedation, usually meperidine.
6. Encourage coughing. Tracheal suction p. r. n.
7. Serial hemoglobins or hematocrits with base line total blood volume when indicated.
8. Foley catheter.
9. Intravenous fluids for maintenance and whole blood for replacement.
10. Drain water from ice chest and add ice q. 2-4 hours as needed.
11. Post-cooling drip of iced milk and antacids via N-G tube.

Table 2

RESULTS OF LOCAL COOLING FOR GI BLEEDING

	Lesion	*Age*	*Sex*	*Episode*	*Days Bleeding*	*Units Blood Given*	*Initial Hct.*	*Hours Cooled*	*Success/Failure*	*Surgery for Lesion*	*Initial Shock*	*Death from Bleeding*	*Hospital Death*	*Remarks*
1.	DU	52	M	2nd	2	4	32%	5	F	Yes	No	No	No	Bleeding pipe stem artery surrounded by large blood clot found at surgery.
2.	PE	73	F	1st	1	10	20%	10	F	No	Yes	No	Yes	Died in septic shock 2 days after cooling. Bleeding decreased.
3.	RP	59	M	1st	3?	7	26%	38	F	No	No	No	Yes	Died in hepatic failure 3 days after cooling. Bleeding decreased.
4.	GU	60	M	1st	2	?	?	5	F	No	Yes	Yes	Yes	Died in hemorrhagic shock during cooling.
5.	GU	37	M	1st	2	6	32%	5	F	Yes	No	No	No	Large gastric ulcer & lg. blood clot found at surgery.
6.	DU	33	M	1st	3	9	18%	6	S	No	Yes	No	No	
7.	DU	38	M	1st	4	10	20%	5	S	No	Yes	No	No	
8.	G	50	M	1st	3	6	37%	9	S	No	No	No	No	
9.	SU	36	M	1st	2	?	?	5	S	Yes	Yes	No	Yes	Died of 60% body burn.
10.	SU	27	M	1st	3	5	25%	30	S	No	No	No	Yes	Died of diffuse astrocytoma.
11.	EV	53	F	4th	2	3	21%	10	S	Yes	Yes	No	Yes	Died in hepatic failure post P-C shunt.
12.	EV	63	M	2nd	2	5	18%	12 18 24	S	No	Yes	No	Yes	Died of extensive superior mesenteric artery thromb. 3 days post cooling.
13. (2)	MU	70	M	1st	3	2	28%	18 20	S	No	No	No	No	
14. (4)	GU	92	M	1st	2	4	23%	18 20 24 18	S	Yes	Yes	No	No	Large gastric ulcer found at surgery.
									5-F 9-S	5	8	1	7	

DU—Duodenal ulcer, RP—rectal polyp, GU—gastric ulcer, G—gastritis, SU—stress ulcer, EV—esophageal varices, PE—pseudomembranous enterocolitis, MU—marginal ulcer.

Discussion

The results presented are those in a small group of patients. It is apparent, however, on comparing the success of Nicoloff and Wangensteen and their group (Table 4) with ours (Table 3), that there is little difference. Crohn,[3] in reviewing a large number of cases of massive upper gastrointestinal bleeding treated medically, found that there was a 15 per cent to 25 per cent mortality rate in patients from 45 to 50 years of age. A direct comparison of the medical and cooling methods of treatment cannot be made, however, because of the large number of patients who could have been treated surgically in the medical group and the small percentage of potential surgical candidates among those that we treated with hypothermia. Similar reasoning would invalidate a comparison of the results of hypothermia with the accepted 5 per cent to 15 per cent mortality rate associated with emergency surgery for massive ulcer hemorrhage. Our patients were, generally speaking, very poor surgical risks and were treated either in desperation or in an attempt to avoid the hazards of emergency surgery with what was, at the time, an experimental procedure.

Table 3

RESULTS IN UPPER GI BLEEDING TREATED BY LOCAL COOLING

Lesion	*No. Pts.*	*No. Controlled*	*Death Due to Hemorrhage*
Duodenal ulcer	3	2	0
Gastric ulcer	6	4	1
Stress ulcer	2	2	0
Esophageal varices	4	4	0
Marginal ulcer	2	2	0
Gastritis	1	1	0
	18	15 (83%)	1 (6%)

Table 4

RESULTS IN UPPER GI BLEEDING TREATED BY LOCAL COOLING.

(From Nicoloff and Wangensteen[11])

Lesion	*No. Pts.*	*No. Shock*	*No. Controlled*	*Death Due to Hemorrhage*
Esophageal ulcer	2	1	2	0
Esophageal varices	12	10	8	3
Gastric ulcer	9	7	7	2
Erosive gastritis	5	2	5	0
Duodenal ulcer	16	10	16	0
"Steroid ulcer"	5	4	3	2
Postop. bleeding	19	13	12	6
Gastric carcinoma	4	4	2	2
Hemorrhagic dyscrasia	3	0	2	3
Total	75	51 (68%)	57 (76%)	18 (24%)

Period of Cooling

Neither the optimal length of cooling needed after bleeding apparently has stopped nor the maximal period of trial cooling advisable before surgical intervention becomes mandatory has been clearly established. We have, in our more recent ulcer cases, continued cooling for about 12 hours after apparent cessation of hemorrhage, at the end of which time iced milk-antacid drip with periodic gastric evacuation is initiated. In cases of slow response or recurrent bleeding we have repeatedly evaluated the patient's general condition and blood volume status. This has disclosed the need for emergency surgery in only two instances. Both patients had been relatively stabilized, with hematocrit above 30 volumes per cent.

The single instance of hemorrhagic death came early in the series and was the direct result of overconfidence in the effectiveness of cooling therapy and relaxation of the house staff's supervision of adequate blood replacement. On the basis of two observations it is apparent that, as anticipated, gastric cooling has little effect on bleeding from the large intestine.

The basic physiological rationale for local cooling is emphasized in the writings of Wangensteen.[13] It is even more appealing in view of the multiple dangers inherent in emergency gastric surgery following massive blood replacement in a labile vascular system and with a stomach usually filled with fresh and clotted blood.

Further Use Necessary

The true clinical value of local cooling in the treatment of gastrointestinal bleeding will not be known until it is employed routinely in a large number of patients who are unresponsive to initial medical management. That there are unforeseen pitfalls is apparent, as exemplified in the case of the patient who died of thrombosis of the superior mesenteric artery three days after his third cooling treatment. Selection of cases should not be a problem. Those in which slow bleeding has persisted despite adequate medical management as well as those with massive upper gastrointestinal hemorrhage should perhaps receive a trial treatment with gastric cooling.

Unit Simple and Effective

The cooling unit previously described has proved effective and is technically simple to operate. The closed system circulation provides safety in volume control and the 1500 cc. capacity practically eliminates the possibility of serious gastric distention from mechanical failure. The danger of frostbite of the gastric mucosa

which had been experienced with refrigerated units[16] is not encountered at routine operating temperatures.

Summary

A modified ice chest intragastric hypothermia unit which is inexpensive, effective, safe and technically easy to operate is described.

Results of the application of gastric cooling in 14 patients bleeding from gastrointestinal tract are presented. Eighteen cooling procedures were performed in cases of upper gastrointestinal hemorrhage with 15 remissions during treatment or up to two days after cessation of cooling.

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A Persistent Problem

Alcoholism, with each passing year, remains a threat to the social, economic, mental, moral and emotional climate of our civilization. As physicians, we have long recognized this entity as a disease state but still can only treat the unfortunate victim with an oft discouraging response.

Perhaps one of the reasons for such a dismal record—a 25 per cent recovery rate at best—is the lack of facilities available to the physician for controlled therapeusis. As the matter now stands, the alcoholic, with his faulty judgment and diminished insight into the devastation he creates, can refuse any help unless there is concomitant psychosis or misdemeanors where the law can enforce care.

Present available aid is insufficient to meet the exigencies of the situation. We do not permit a child or a psychotic to render judgments inimicable to their welfare. Yet the alcoholic is no more capable of unaided self-preservation. There are programs in the discussion and perhaps planning stages to make it possible to certify alcoholics to special hospitals without their consent when their families can no longer permit continuing destructive behavior. We, as the doctors involved in the frustrating effort to help these addicted victims, should encourage the realization of such a program as outlined above. In this way much can be done to diminish this scourge.—Westchester Medical Bulletin.

Advanced Intraligamentary Pregnancy

(Case Report)

Robert E. Stone, M. D.

ADVANCED extrauterine pregnancy is an unusual obstetrical complication that presents a problem not only in diagnosis but also in management. For these reasons the following case is reported, to be added to those already appearing in the literature.

The Author

- **Robert E. Stone, M. D., 1321 Quarrier Street, Charleston, W. Va.**

Case Report

Mrs. B. T., aged 30 years, white, gravida IV, Para III, aborta O, was admitted to the hospital on September 22, 1959, in the third trimester of pregnancy, complaining of bleeding. Her last normal menstrual period was January 7, 1959. In March, 1959, she had an episode of severe abdominal pain, with fainting. She was seen at that time by her family physician who thought that she had an intrauterine pregnancy and who treated her at home conservatively with improvement.

On initial examination in the referring doctor's office, it was difficult to outline the uterus and it was thought that a myoma existed in the left adnexa; this diagnosis, however, was not conclusive.

The patient stated that for the most part the fetal movements were confined to one particular area and that they were not as "free" as those associated with previous pregnancies. Four weeks and, again, two weeks prior to admission there was moderate painless vaginal bleeding which subsided with bed rest. At no time was the bleeding heavy nor bright red. Just prior to admission she began bleeding again and stated that she had felt no fetal movement for two or three weeks.

Physical examination on admission revealed a well-developed and well-nourished white female. The pertinent physical findings were limited to those observed on pelvic examination. There was moderate dark red bleeding. The cervix was 1.5 cm. dilated and was displaced markedly toward the right. No presenting part could be felt through the cervical canal. There was a firm, globular, 8 to 10 cm. mass lying anteriorly in the right adnexal region and extending above the right inguinal ligament. Occupying the remainder of the pelvis was a mass consistent in size with a seven-month gestation. This larger mass extended into the cul-de-sac and was of a soft, cystic consistency. No fetal heart could be heard.

Laboratory.—Hemoglobin 12.8, WBC 12,500, with a normal differential. Urinalysis (catheterized specimen) was normal. An x-ray of the abdomen was reported as follows: "The placenta lies anteriorly and appears larger than normal. The bones of the fetus are demineralized. The findings suggest a dead fetus." The radiologist thought that he could outline the uterus and that the pregnancy was intrauterine.

With the diagnostic impression of intrauterine pregnancy with fetal demise, an intravenous infusion of 500 cc. of 5 per cent glucose in water with 1 ampule of pitocin was started slowly. This failed to initiate any labor. After twenty-four hours, re-evaluation of the patient's condition strongly suggested extrauterine pregnancy with fetal demise. A pitocin drip was started again and it was noted that the mass in the right lower quadrant underwent regular rhythmic contractions, their rate depending on the speed of the pitocin drip .

Operation.—A diagnosis of extrauterine pregnancy was made, and exploratory laparotomy was accomplished. At operation, it was noted that the uterus was displaced anteriorly into the right lower quadrant of the abdomen. The left infundibulopelvic ligament and the left round ligament were stretched across a large mass lying within the leaves of the left broad ligament. On palpation it was found that the bowel was not involved in the mass. The posterior leaf of the left broad ligament was entered and a macerated fetus

Submitted to the Publication Committee, April 12, 1962.

weighing approximately 4½ pounds was delivered. The cord was clamped and cut close to the placenta which was implanted on the lateral wall of the pelvis. Feeling that the risk of removing the placenta would be great because of possible involvement of the uterine, iliac and hypogastric vessels, it was left undisturbed. The incision in the posterior leaf of the broad ligament was carefully closed. There was no evidence of bleeding when this was completed. The abdomen was then closed. The patient received two pints of blood during the procedure and was taken to her room in good condition. She had an uneventful postoperative course and was discharged on the eighth postoperative day.

Follow-up examinations revealed the placental mass to have decreased in size from 19 x 17 cm. at two weeks postpartum to 16 x 7 cm. at six weeks.

The patient was last examined in May, 1960. Her menses were regular and she was free of pelvic complaints. Examination was essentially negative except for a 6 to 7 cm. mass occupying the left broad ligament and displacing the normal uterus anteriorly and toward the right.

Subsequently moving out of the state, the patient was lost to further follow-up.

Summary

A case of advanced intraligamentary pregnancy in a patient aged 30 years, gravida IV, Para III and aborta O is reported. Treatment was surgical and was followed by an uneventful postoperative course and complete recovery.

Mesmer Revisiting

The past decade or so has seen, on the one hand, a tremendous resurgence of the authentic medical uses of a most valuable therapeutic tool—hypnosis—and, on the other hand, also a resurgence of its prostitution by quacks, charlatans, and fakers. The present interest in the uses of hypnosis in medicine is but another phase in the curious cycles, alternating between great enthusiasm and almost complete rejection, that have characterized the history of hypnosis since the time of Mesmer, and even before. Hypnotism has been known in one form or another, and used as a means of healing (mainly in a religious setting) by almost all of the major civilizations. Its important medical applications today are in the treatment of psychoneuroses and psychosomatic disorders; and, in selected subjects, for the production of anesthesia or analgesia in surgical, dental, and obstetrical patients.

It will come as no surprise to the thinking physician that fringe groups should seek to utilize hypnosis for their own, rather than patients', benefits. In point of fact, during the last few years these fringe groups have been overdramatizing, overpopularizing and exploiting hypnosis through the press, the radio, and television to the extent that the honest physician is scarcely willing to admit of a nodding acquaintance with the technique. This is an unfortunate state of affairs, for the medical usages of hypnotism are sufficiently important to warrant their continued utilization, when needed, for specific indications.

The misuse of hypnotism is of genuine concern to the medical profession, for these are psychotherapeutic techniques and cannot be regarded independent of psychological medicine. The dangers of hypnotism may be exaggerated in some quarters, but they are nevertheless very real: for hypnosis may involve the development of a relationship between the hypnotist and subject which can release powerful emotions that the inexperienced hypnotist is incapable of controlling if he is ignorant of either the psychological makeup of his patient or the morbid complications of the hypnotic state.

The crux of the matter is that *proper* and *adequate* training must be the sine qua non for the employment of hypnosis by any moral and ethical physician. A plethora of courses is available (including five-lesson, mail-order, correspondence courses!), but centers for training under proper auspices are sharply lacking. As one worker phrased it: "Hypnotic induction can be as readily learnt as the technique for making an abdominal incision. The real problem is what to do . . . after that." If Mesmer's revisitation is to be more than just another phase in the curious cycles of enthusiasm and rejection, the most careful consideration will have to be given to the training of those who wish to use hypnosis for legitimate medical purposes.—D. M. L., Jr., in Connecticut Medicine.

Upper Extremity Embolectomy*

Thomas J. Tarnay, M. D., Emil L. Mantini, M. D., and Walter H. Moran, Jr., M. D.

UPPER extremity emboli are unusual even in large teaching centers. The fact that four such cases were seen during the first nine months of operation of the West Virginia University Hospital prompted the present report.

Background

It is difficult to date the first recognition of arterial emboli. Although John Hunter had a profound curiosity with reference to coagulation *in vivo,* arterial embolism first was described by Virchow, in 1895, and an unsuccessful attempt at embolectomy was made by Sabanieff the same year. The work of Carrel[1] in blood vessel suture techniques during the early 1900's paved the way for the first successful embolectomy, which was accomplished by Labey, in 1911. Key, in 1913, performed the first successful upper extremity embolectomy although Lecene, in 1909, had attempted it and failed. Key's[6] monograph remains an authoritative work on the subject.

Etiology and Incidence

Most emboli originate from the heart, about one-half in patients with rheumatic heart disease and the remainder in patients with myocardial infarction. The incidence of emboli is greatest in mitral stenosis and auricular fibrillation. Eighteen per cent of all emboli terminate in the upper extremity; 2 per cent involve the subclavian artery, 6 per cent obstruct the axillary artery and 10 per cent occlude the brachial artery. Radial and ulnar involvement are uncommon. The right side is more often affected than the left. Women have a slightly greater incidence than men. Multiple emboli are common.[3, 5, 7, 8]

Pathogenesis

Emboli characteristically lodge at points of narrowing. In the upper extremity the subclavian artery may be involved at the vertebral branch, the axillary artery at the origin of the subscapular, the brachial artery at its profunda branch and at its ultimate bifurcation.

Presumably because of associated spasm, gangrene occurs much more frequently after emboli than after simple vessel ligation. The constriction aids in the formation of secondary thrombosis in the distal vessel. Eventually irreversible intimal changes occur that cause rapid re-thrombosis after surgery.[2, 4, 6, 7, 8]

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Signs and Symptoms

Although the most striking symptom is pain which frequently coincides with the vascular occlusion, pain may be absent and the patient may complain of numbness and areas of paresthesia. The extremity becomes cold and livid. Muscle grip weakens and finally paralysis ensues. The pulse is not palpable beyond the embolus.

Management

A patient with an arterial embolus presents an acute emergency. Ideally, four procedures should be done while the patient is being prepared for operation:

(1) A thorough medical history and evaluation are directed toward correction of any arrhythmias and improving cardiovascular function.

(2) An antispasmodic such as Papaverine should be given intravenously or preferably intra-arterially.

(3) A stellate ganglion block should be performed. (The purpose of the latter two procedures is to diminish spasm and enhance collateral circulation.)

(4) Anticoagulants (Heparin) should be employed.

Arteriograms seldom are necessary since the site of obstruction usually is evident. Occasionally in the obese patient an arteriogram may be useful; the intravenous technique is adequate.

Although there is some disagreement concerning which patients should be subjected to embolectomy, we feel that in all cases of obstruction

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Submitted to the Publication Committee, April 10, 1962.

at and proximal to the brachial bifurcation, the patient should receive the benefit of exploration. Avoidance of gangrene should not be the only criterion of success but, also, a useful functional arm without paresthesia or causalgia.

Patients with emboli below the bifurcation usually do well under conservative management consisting of antispasmodics, repeated stellate ganglion blocks and anticoagulants.

When operation is indicated, either local or regional block anesthesia is the modality of choice. The artery should be exposed at the site of obstruction and, with tapes above and below, a transverse incision made over the embolus. It is preferable not to tighten the tapes prior to the incision since the thrombus may be crushed against the vessel wall and its removal rendered difficult. The arteriotomy should not be closed until good back-bleeding is assured. If the situation is dubious, an incision should be made over the radial artery and the vessel inspected after a trial closure of the proximal arteriotomy. If pulsations are absent, the artery should be opened and flushed retrograde with saline or dextran to dislodge the secondary thrombi. When good flow has been established both arteriotomies should be closed after distal flushing with an anticoagulant. Since oozing and hematoma formation are easily noted in the upper extremity, we prefer to work under anticoagulants during surgery rather than wait until the postoperative period to begin their administration. We would much rather re-operate for hemostasis than be without this additional aid. In the unusual case of subclavian embolus the axillary artery should be exposed and the embolus brought down by gentle instrumentation much as an aortic saddle embolus is delivered from below.

Operation should be done as soon as possible in all cases. The "golden period" still is the first ten hours, as originally set forth by Key. Even when this period has elapsed, however, there are numerous reports of benefit. The recovery room should be heated to 85°-90° F. to effect reflex vasodilation. The fingers should be wrapped in cotton or lamb's wool and the extremity watched carefully for pulse changes. Re-operation should be performed promptly if the pulse subsequently disappears. Anticoagulant treatment should be maintained for at least ten days.[1,2,3,4,5,6,7,8,9]

Prognosis

The best local results are obtained by operation during the first ten hours. The circulation usually is restored in this period and very often radial pulses are present. The ultimate prognosis, however, depends not on the extremity but on the disease responsible for the embolus. Even now the prognosis is poor. Martin, as late as 1959, listed a 50 per cent hospital mortality usually related to the associated heart disease characterized by recurrent emboli. Goldowsky, in 1960, observed a 37 per cent hospital mortality with only 44 per cent surviving three years and 40 per cent surviving five years.[5,10]

Case Reports

Case 1.—A 65-year-old farmer was awakened fourteen hours prior to admission with pain in the left thumb, spreading to involve the entire arm below the elbow. Sensation disappeared over the first three digits but with time began to return. There was never any paralysis.

Physical examination revealed an enlarged heart with evidence of fibrillation and a diastolic murmur consistent with mitral stenosis. The left hand was cyanotic, particularly the thumb and the second and third fingers. It was cold but movement and sensation were present. The brachial pulsations were not felt below the antecubital fossa.

Sixteen hours after the onset of symptoms, operation was performed under brachial block anesthesia. The radial artery was opened and a #18 Teflon catheter passed retrograde evacuating bits of clot by means of alternating suction and irrigation with saline containing an anticoagulant. Free pulsatile flow ensued and the maneuver was repeated distally. Some retrograde bleeding was obtained as well. The artery was closed and pulsations were noted beyond the suture line. After operation, color and warmth returned to the first three digits but the radial pulse never became palpable. Anticoagulants were administered during operation and were maintained after discharge.

This unconventional method of management was elected because it was felt that the embolus had lodged primarily in the radial branch of the brachial bifurcation since the color to the 4th and 5th digits was good. If pulsatile flow had not been obtained by the maneuvers performed, an arteriotomy would have been made in the region of the antecubital fossa.

The question of mitral commissurotomy was discussed with the patient, but he refused the procedure.

Case 2.—A 66-year-old draftsman entered the hospital with a cold, painful, right forearm of about ten days' duration.

Physical examination failed to reveal any evidence of heart disease. The right arm was cold

and blue to midforearm. Although the brachial artery was pulseless, there was an easily palpable subclavian pulsation. The right hand was anesthetic and there was marked weakness of all forearm muscles. Occlusion of the right axillary artery was suspected. A stellate ganglion block was performed promptly and anticoagulant administration begun. Because of the long history operation was delayed until the next morning.

The embolus was found just proximal to the origin of the subscapular artery. Free blood flow was obtained from both directions but radial pulsations were absent. Accordingly, an incision was made in the wrist and the radial artery found to be pulseless. By use of the retrograde flush technique good bleeding was obtained. Upon closure of the arteriotomies good radial pulsations were noted but these soon ceased in the recovery room. Nine days later, a below elbow amputation was performed and healed per primum. The source of the embolus in this instance was not clear.

Case 3.—A 78-year-old housewife noted a sudden onset of pain in the left upper arm eight hours prior to admission. She had a history of heart disease and had been taking digitalis for five years.

Physical examination revealed full neck veins, some fine rales in both lung bases and some cardiac enlargement, with a grade II systolic murmur at the apex. The left arm was cooler than the right. Motor function was intact. Brachial artery pulsations ceased at mid-upper arm. The hand was pale and cyanotic; sensation was present. The impression on admission was brachial artery embolus.

Nine and one-half hours after the initial episode, a small thrombus was removed from the left brachial artery under local anesthesia. Additional thrombi were washed retrograde from the radial artery. Anticoagulant treatment was initiated. Immediately after operation there was return of color but radial pulsation was not noted until the following morning. Because of oozing, re-operation under local anesthesia was performed and the bleeding was controlled without discontinuing anticoagulants. Anticoagulants were maintained for ten days. An intravenous arteriogram made shortly before discharge demonstrated a patent arterial system.

Case 4.—A 64-year-old housewife was found on the floor, unconscious and paralyzed. She had had mitral stenosis for at least fifteen years but never required anticoagulants.

Physical examination revealed a frail, uncommunicative woman with obvious aphasia and right hemiparesis. The heart was not grossly enlarged; an aortic diastolic murmur and an apical diastolic rumble were noted. Examination of the extremity indicated the absence of pulsations below the left subclavian artery and revealed the arm to be cold, pale and unreactive. The right femoral pulse was absent and in the left leg there were no palpable pulses beyond the left femoral. The admitting impression was mitral stenosis with emboli to the brain, left axillary artery, right femoral artery and left femoral artery.

Because of the multiplicity of emboli it was felt imperative to rule out a carotid embolus. A carotid arteriogram failed to reveal any obstruction in the extracranial carotid system.

Six hours after the onset of symptoms emboli were moved from the right femoral artery and left axillary artery under local anesthesia. No embolus was found in the left femoral or popliteal arteries. Although there was good backbleeding from the axillary artery after embolectomy, no radial pulsations were present and accordingly an incision was made over the radial artery and saline containing an anticoagulant flushed antegrade through the previous arteriotomy. Sudden blanching occurred in the vessel, indicating that the system was patent. Accordingly, the arteriotomy was closed and postoperatively the radial pulse was palpable. Anticoagulants were begun and several hours later a hemiparesis developed on the other side. The patient expired eleven hours after admission. Post-mortem examination indicated rheumatic heart disease with mitral stenosis and massive intracerebral hemorrhage with destruction of the right internal capsule.

It would appear advisable not to use anticoagulants in patients with cerebral emboli.

Discussion

Many observers state that upper extremity emboli can be adequately treated by conservative measures and, despite significant mortality associated with the systemic effects, a significant proportion of such patients now do survive. Embolectomy, however, provides the patient with the best functional arm and hand possible. Inasmuch as the operation is performed under local anesthesia and involves little dissection, it carries apparently relatively slight risk, even in extremely ill patients. Embolectomy is wholly justifiable to avoid the risk of gangrene and amputation.

When delay is anticipated before definitive treatment can be started, there should be no hesitation in performing a stellate ganglion block and instituting anticoagulant administration. The likelihood of retrograde thrombosis thus will be reduced.[5, 9, 10]

Conclusions

Although in upper extremity embolectomy the "golden period" encompasses the first ten hours, a patient should not be denied operation beyond that period as benefit still may ensue. Stellate ganglion block, antispasmodics and anticoagulants should be used.

Upper extremity embolectomy is indicated at or proximal to the brachial bifurcation. A transverse rather than a longitudinal arteriotomy should be employed to minimize narrowing. Subclavian emboli can be removed through an axillary arteriotomy.

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Prospects for Improvement

Over 300,000 babies born last year are alive today as a result of the great advances in medical care of the last 45 years. That is to say, these infants represent the number of additional lives saved in a single year because the infant mortality rate has declined so sharply since the early 1900's. Measured by any yardstick, this is wonderful progress. Yet, no matter how satisfying, an analysis of infant deaths shows that much remains to be accomplished. If the level of survival attained in Utah—the state with the best record—had been achieved throughout the country last year, for instance, some 27,000 more infants would have lived.

Unfortunately, many aspects of infant mortality still defy measurement. Among other types of data, statistics are not available on infant deaths in relation to educational levels of parents, although there is every reason to believe that lack of education would correspond directly with higher levels of infant mortality. Education may well be a key, then, to future increments of progress. The first responsibility for reducing infant mortality lies with the prospective parents. They must understand when to seek medical advice and where to look for it. They must be aware of the basic requirements of sanitation and nutrition, of the need for periodic professional consultation, and of the inadequacy of many folk methods.

Success in protecting the newborn also correlates with obstetrical care in the hospital. Now that over 96 per cent of all babies are born in hospitals, we recognize that the improvement in their survival rate has not come as a matter of course. It results from the development and availability of modern diagnostic and treatment facilities and the use of larger staffs of trained personnel for the prevention of infection. Moreover, if infant and maternal deaths in hospitals are to be further reduced, major concentration is needed on every precautionary measure developed in such facilities. Future reductions in infant mortality will inevitably be less dramatic than those of the past, simply because much has already been accomplished, but they will be rewarding in terms of the value we place on the life of each child.—George Bugbee, Director, Health Information Foundation.

The Closed Chest Method of Cardiopulmonary Resuscitation: Benefits and Hazards

An original statement on the closed chest method of cardiopulmonary resuscitation prepared by the American Heart Association has been revised to incorporate recommendations of an Ad Hoc Committee of the Industrial Medical Association appointed for this purpose. In its present form the following statement is subscribed to by the Industrial Medical Association, the American Heart Association, and the American National Red Cross:

In view of the growing interest in the closed chest method of cardiopulmonary resuscitation, and the possible dangers in its indiscriminate use, the following statement has been prepared as a guide to the public regarding the present place of this new technique. The closed chest method of cardiopulmonary resuscitation has been proved effective as a medical procedure in certain cases of stoppage or disruption of the heart beat. However, it is to be considered a temporary method and additional medical treatment, which may include the use of drugs and an electric defibrillator, is usually required to restore the circulation permanently.

The heart beat may stop as a result of a variety of conditions or circumstances such as water submersion, electrical shock, asphyxiation, heart attack, or during anesthesia or surgery. Most people who experience sudden stoppage or disruption of the heart beat (cardiac arrest) cannot be saved even under ideal circumstances in a hospital. The least measure of success has been experienced in coronary heart "attack" cases. However, the prompt use of cardiopulmonary resuscitation has enabled lives to be saved which previously might have been lost. The new technique of closed chest cardiac massage makes it possible to continue blood circulation without opening the chest, thus greatly extending the possibilities for attempting saving of life. Consequently, it is the desire of all concerned to achieve widespread use of this method where it can be used safely and effectively.

The public should be advised, however, that the application of closed chest cardiopulmonary resuscitation calls for a working diagnosis of the victim's condition. It is important to be sure that the circulation has actually stopped because the method involves certain hazards. Reported injuries to patients have included damage to the heart and liver, internal bleeding, multiple rib fractures, and puncture of the lungs. In untrained hands the risk of injury is increased. It is particularly important to avoid the possibility of inflicting serious injury on a person under the mistaken impression that cardiac arrest has occurred when the individual has simply fainted or lost consciousness from some other cause. Successful application of closed chest cardiopulmonary resuscitation depends on thorough and careful training. One is most unlikely to be able to achieve artificial blood circulation by this method if his only training is from reading written instructions.

In view of these facts, it is suggested that closed chest cardiopulmonary resuscitation be applied only by carefully trained personnel so that it may be utilized with the greatest safety and effectiveness. Two qualified persons are preferable because it is necessary to maintain artificial respiration at the same time the heart is being massaged externally. A decision as to whether training in this procedure should be extended to certain segments of the general public must be postponed until further experience accumulates.

The organizations joining in this statement believe that emphasis should be placed at this time in training physicians, dentists, nurses and specially qualified emergency rescue personnel so that the procedure will become more widely available.—Journal of Occupational Medicine.

The President's Page

Legislative Program

THE West Virginia State Medical Association is interested in several important bills which will be introduced in the West Virginia Legislature during the 1963 regular session which will be convened on January 9. We feel it is in the public interest to promote passage of these measures. Foremost among the bills we hope will be enacted is one which would provide for the establishment of a Medical Examiner's System. This same bill was introduced during the 1961 session and was passed several days prior to adjournment by the House of Delegates, with no action being taken by the Senate.

The bill was drafted originally by the West Virginia Association of Pathologists, a Section of the State Medical Association, and it provides for a Commission on Medical Examinations with a Chief Medical Examiner who would have the power to regulate cremations and autopsies. Further, it would empower the medical examiner to investigate deaths.

The West Virginia State Medical Association does not mean to criticize the present coroners or acting coroners, but it does intend to work toward the establishment of a new system to replace the outmoded one that now exists. The proposed new legislation has been tested in our neighboring states and has proved to be very effective. We consider the passage of this legislation essential.

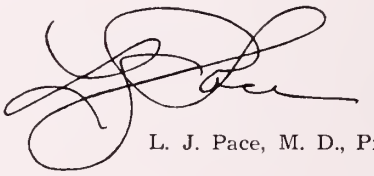
In the past the medical profession and members of lay organizations interested in the improvement of the Mental Health Law in our State have been disappointed in the hesitancy of our legislators to accept changes which have been considered vital to the improvement of our mental health system. At present the Department of Mental Health, the West Virginia Association for Mental Health and the West Virginia State Medical Association are proposing certain changes in our antiquated commitment laws. These proposals submitted by the Mental Health Committee of the State Medical Association apply only to those portions of the Code pertaining to the admission and discharge laws for the mentally ill. These proposals would change the concept of the mentally ill from being criminal in nature to one of medical. He would be a patient instead of an inmate, and it would serve to expedite admission to a psychiatric hospital while preserving the civil rights of the patient. Further, it would broaden the scope of treatment inasmuch as the patient could be admitted to either a State supported institution or a private psychiatric facility approved by the Director of the Department of Mental Health. Here again we feel this is a much needed change.

There are those who desire repeal of the Pop Tax. Our Association believes this would be detrimental as it would benefit but a few while harming a great many. The revenue derived from this tax is urgently needed to continue the operation and expansion of the West Virginia University Medical Center.

The West Virginia Chapter of the American Academy of General Practice submitted to our House of Delegates at the Annual Meeting in August a resolution dealing with autopsy consent. At present there is no law covering who may sign for autopsy consent and hence many autopsies are lost for this reason. All hospitals are required to secure autopsies on twenty-five per cent of the deaths occurring in each hospital in order to maintain accreditation. Hence, it is necessary that we make every effort to legally secure the actions of those who obtain and perform the autopsies. The House of Delegates unanimously adopted this resolution.

I feel we should cooperate with the State Health Department in seeking an increase in its 1963-64 appropriation. All of us in the profession are aware of the efficient operation of this Department in spite of an inadequate budget. The Department is requesting an additional appropriation of $500,000 to expand its scope of services and to provide well-deserved salary increases for employees of the Department.

It behooves us as physicians to give our full support to all these proposals which will result in improved health care for the citizens of West Virginia.



L. J. Pace, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 346-0551.

EDITORIALS

GET OUT THE VOTE

Physicians and their families have been alerted frequently to the importance of the general election on Tuesday, November 6, and the call may become so repetitive it is a bit tiresome. We are aware that the forthcoming election is of the utmost importance to the preservation of our present system of medical practice—a system which has given our country the finest health care in the world.

In spite of past performance, there are those in Washington who seem to be determined to seek changes in practice procedures that would bring us into closer alignment with the completely socialized medical service of Europe. In fact it has been stated that we are behind the times, behind European procedures because we chose to preserve our traditional procedures.

It is not necessary to go to England and Europe to see socialized medicine in action. Just recall the recent socialistic development in medical care in the Province of Saskatchewan, Canada. In that Province the citizens and the members of the medical profession, after assurance that no government action would be undertaken that was not mutually agreeable, were given the official double cross. Consequently, a great profession has been harnessed to the whims of politicians and made wholly subservient to government. The members of the medical profession are left without any representation whatever in the conduct of their own business. It can happen here!

Physicians have been urged to become politically active. The week prior to the general election is the time when our interest and activity can be most helpful. After this election it may be too late—history indicates no backward trend in socialistic infiltration.

Physicians are urged to discuss with all candidates their position on King-Anderson type legislation. On election day support only those men and women who oppose the intrusion by the government in the private practice of medicine.

Devote the day of November 6 to election activities. Be dedicated to getting your family, employees and your friends to the polls. A full vote will assure our success.

UPPER EXTREMITY EMBOLECTOMY

Elsewhere in this issue of *The Journal* may be found an article dealing with upper extremity embolectomy. The authors state that although this condition is not common, nevertheless, four such cases were seen during the first nine months the West Virginia University Hospital was in operation. These cases are described

briefly. The average age of the patient was about 68 years.

It is pointed out that most emboli originate from the heart, and the greatest incidence is found in mitral stenosis and auricular fibrillation. Eighteen per cent of these emboli terminate in the upper extremity.

The most striking symptom is pain which frequently coincides with the vascular occlusion, but pain may be absent and the patient may complain only of numbness and paresthesia. The extremity becomes cold and livid, there is a weakening of the muscles followed by paralysis. Beyond the site of the embolism the pulse is not palpable.

It is emphasized that the patient suffering an arterial embolism presents an acute emergency, and an operation in all cases should be done as soon as possible. The most effective period, which falls within the first ten hours, is spoken of as the "golden period;" but operative procedures even beyond this time may often be of benefit.

It is unnecessary to stress the importance of early and proper management of such cases, since embolectomy avoids the grave risk of gangrene and subsequent amputation.

THE NEW AMA-ERF LOAN PROGRAM

A new nation-wide loan plan is giving medical students, interns and residents an opportunity to supplement the financing of their training in a business-like way. Launched recently by the American Medical Association's Education and Research Foundation, the Guarantee Loan Program is predicated on individual responsibility, not subsidy. The benefits to the student are clear. He can get money when he needs it most and pay it back when he can afford to. He can devote more of his training days preparing for his profession, less to working on part-time jobs to meet expenses. A recent study indicates that three out of ten medical students work more than 20 hours a week. He learns early in life the value of careful budgeting and financial planning.

The benefits to the profession and to the public are also clear.

Students will be encouraged to complete their training and enter practice. As awareness of the loan program grows, more young people will realize that lack of financial resources need not be a barrier to medical education.

Under the plan, an approved applicant may borrow up to $1,500 in any one-year period and as much as $10,000 over a seven-year training period. During his training, he makes no interest or principal payments.

Repayment starts five months after he enters practice or other full-time employment, on the theory that he is then financially able to begin meeting his obligations. During the training period each loan carries a fixed rate of simple interest, currently 5½ per cent. When he enters practice, the young doctor can refinance all of his loans into a single note with a 3½ per cent add-on rate and a pay-out period of up to 10 years.

Medical schools and hospitals help select loan applicants. A bank approves the loan, after reviewing the student's other sources of income (scholarships, family support, earnings, etc.) and projected expenses. The AMA-ERF co-signs each note to guarantee its repayment.

The loans currently are made by the Continental Illinois National Bank and Trust Company of Chicago. They are secured by an AMA-ERF fund representing contributions from physicians, medical societies and industry. The bank will lend up to 12½ times the amount in this fund. The fund now has $670,000. A total of $5,900,000 already has been loaned or committed to 3,188 applicants, this figure including the principal and the amount of interest expected to accrue over the lifetime of these loans.

Twenty-eight of the borrowers are in training in West Virginia.

Remaining guarantee funds provide uncommitted credit of $2,300,000. This sum must be augmented to meet the expected increase in applications in the new school year. The loan program is one in a series of projects sponsored by AMA-ERF, successor to the American Medical Education Foundation and the American Medical Research Foundation.

The AMA-ERF loan program deserves the support of all of us. Each $100 contribution will enable some student, intern or resident to borrow $1,250 which, when repaid, will again be available for another student.

It's one of the best ways we know of giving credit where credit is due.

The Trademark of Quality

Most of us physicians learn to respect the competence of a particular pharmaceutical house. Their trademark becomes a sign of quality to us and I hope we don't do away with what seems to me the consumers' best guarantee of value—the identification with a particular drug house.—William C. Menninger, M. D.

GENERAL NEWS

242 Attend Rural Health Conference At WVU Medical Center

The 15th Annual Rural Health Conference, held for the first time at the West Virginia University Medical Center on October 4, was enthusiastically received by the 242 persons who attended. The theme for the one-day meeting was "The Program at the West Virginia University Medical Center and How it Benefits the Rural Areas of West Virginia."

The West Virginia State Medical Association sponsors the conference annually under the auspices of its Rural Health Committee, with the full cooperation of the West Virginia Home Demonstration Council, the West Virginia Farm Bureau, the State Department of Health, the West Virginia Congress of Agriculture, and the Agricultural Extension Division of West Virginia University.

Doctor Coyner Presiding Officer

Dr. Martha Jane Coyner of Harrisville, the presiding officer, called the meeting to order at 10 A. M. Doctor Coyner is immediate past chairman of the Rural Health Committee of the State Medical Association.

The invocation was given by the Rev. Joseph C. Gluck, Director of Student Affairs at West Virginia University.

Dr. Kenneth E. Penrod, Vice President-Medical Center, and Dr. Clark K. Sleeth, Dean of the School of Medicine, were the speakers at the morning session.

Dr. L. J. Pace of Princeton, President of the State Medical Association, delivered an address of welcome at the opening of the afternoon session. The principal speaker was Norman Laughlin of Fairmont, Manager of the Upper Monongahela Valley Association.

Doctor Penrod gave a brief general outline of the operations of the Medical Center and the various programs offered in the health sciences.

Four Primary Educational Functions

Doctor Sleeth's main morning address was on the subject "Why Don't We Have More Doctors in Our County?" He pointed out that within the School of Medicine there are four primary educational functions as follows:

(1) Taking the young man or woman, after three or four years of college and, in an additional four-year period, preparing them to receive an M. D. degree; (2) picking up the newly-created M. D. and carrying them through internship lasting at least one year and through residency lasting up to four or five additional years; (3) continuing education for physicians in practice; (4) the education of future teachers to instruct the basic science subjects of medicine.

Doctor Sleeth, using various statistical information from the 1960 Census, attempted to correlate population and physician density with such things as average income of West Virginians. While he pointed out that more study is needed on where and why doctors locate in certain areas, his primary conclusions were that population density, while apparently a factor in determining the location of physicians, is not the only factor, and that the economic factor is not the sole determinant of where doctors settle.

Dr. Martha Jane Coyner of Harrisville, center, presiding officer at the annual Rural Health Conference, is shown with Dr. L. J. Pace of Princeton, President of the West Virginia State Medical Association, and Norman Laughlin of Fairmont, speaker at the afternoon session.

In general, Doctor Sleeth noted, physicians gravitate toward areas with an adequate number of hospital beds for the population. But exceptions were noted. For example, four general hospital beds per 1,000 population is considered adequate. The ratio in one county is 5.7 beds per 1,000 persons, but there is only one physician for every 3,900 persons.

At the conclusion of Doctor Sleeth's address, those attending the conference were separated into groups and conducted on a tour of the Medical Center by junior and senior students in the School of Medicine. Following the tour, the conferees were luncheon guests of the State Medical Association at the Medical Center Cafeteria.

Address by Dr. L. J. Pace

Dr. L. J. Pace of Princeton, President of the State Medical Association, was introduced by Doctor Coyner and delivered a short address of welcome to open the afternoon session.

Dr. L. J. Pace of Princeton, right, President of the State Medical Association, is shown with Dr. Clark K. Sleeth of Morgantown, Dean of the WVU School of Medicine, and Dr. Andrew E. Amick of Lewisburg, at the Rural Health Conference. Doctor Amick is a member of the Rural Health Committee and a past president of the State Medical Association.

He commended the representatives of various groups in attendance for their continued interest in attempting to solve West Virginia's rural health problems.

Doctor Pace said members of the medical profession in West Virginia realize that there are many problems remaining to be solved in meeting the health needs of the citizens in rural areas. Of paramount concern, he said, is the diminishing number of young physicians who are establishing their practices in smaller communities.

He also expressed the appreciation of the State Medical Association to Doctor Coyner and Drs. Sleeth and Penrod and members of the Medical Center staff for their "excellent program and wonderful hospitality."

"We sincerely hope that the young men and women who are receiving their professional education at this Medical Center will decide to remain in West Virginia following graduation," Doctor Pace said. "All of us can be of tremendous help in seeing to it that they do cast their lot with West Virginia."

'Concerted and Long-Range Effort'

Mr. Laughlin, speaking on "What The Community and Its Citizens Can Do to Encourage Physicians to Practice in Rural Areas," said residents and leaders in these sections of West Virginia should "make a concerted and long-range effort" to attract home town boys and girls back to their original communities to practice medicine.

"In short," he said, "sell them on coming home. This might well be one answer to the lack of doctors in rural areas of West Virginia.

"Lack of facilities with which to practice modern medicine, lack of atmosphere, lack of professional companionship and lower financial rewards all contribute to the problem of recruiting doctors in rural areas. And we might as well face the facts, the reason farmers are leaving their farms is the one and same reason doctors are not settling in rural areas—financial insecurity."

He urged rural residents of West Virginia to reverse the trend of movement to the urban areas because "our rural communities have something to sell." He said rural areas have many of the things that are desired by persons now living in congested urban areas. He named such things as small town hospitality, the intimacy of a small community, and the high stature which a doctor or professional man holds in such a community.

Doctor Coyner served as moderator during the question and answer period following Mr. Laughlin's address. During that portion of the program, Mrs. Carolyn A. Tingler of Pennsboro explained how the citizens in that community had worked together to attract a physician.

Mrs. Tingler said the people of the area would soon construct and equip a building which would be rented to two physicians and a dentist. She said this method might well be the answer for other rural areas which need doctors.

Doctor Coyner, in closing the program, said her decision to enter practice in a rural area was "the most rewarding of my life—one that I shall never regret."

Dr. Charles E. Staats of Charleston, center, chairman of the Rural Health Committee of the State Medical Association, talks with Dr. Kenneth E. Penrod, Vice President of the West Virginia University Medical Center, and Dr. Clark K. Sleeth, Dean of the School of Medicine. Drs. Penrod and Sleeth were speakers at the morning session of the 15th Annual Rural Health Conference.

In the other picture, Mrs. Daniel H. Bee of Indiana, Pennsylvania, left, is shown with Mrs. Howard G. Weiler of Wheeling, right, president of the Auxiliary to the State Medical Association, and Mrs. Vernon L. Dyer of Petersburg, immediate past president. Mrs. Bee is the wife of the president of the Pennsylvania Medical Society and regional chairman of the Rural Health Committee of the Woman's Auxiliary to the American Medical Association.

Dr. Seigle W. Parks of Fairmont, left, is shown with Norman Laughlin, also of Fairmont. Mr. Laughlin, Manager of the Upper Monongahela Valley Association, was principal speaker at the afternoon session of the Rural Health Conference.

Film on 111th Annual AMA Meeting Produced by Schering Corp.

Medifilm Report IV, presenting highlights of the 111th Annual Meeting of the American Medical Association in Chicago last June, is now available for showings before medical and allied groups. The film was produced by Schering Corporation in cooperation with the AMA's Council on Scientific Assembly.

The 30-minute, 16 mm black and white sound film features scientific exhibits, lectures and panel discussions. Dr. Jack DeTar of Milan, Michigan, past president of the American Academy of General Practice, is narrator for the film.

County medical societies may obtain a copy of the film by writing to the AMA Film Library, 535 N. Dearborn Street, Chicago 10, Illinois, or to the Audio-Visual Department, Schering Corporation, Union, New Jersey.

ACCP Course in Detroit

A Postgraduate Course on "Cardiopulmonary Diseases and Occupation" will be sponsored by the American College of Chest Physicians and the Industrial Medical Association at the Statler Hotel in Detroit, Michigan, December 3-7.

One of the features of the meeting will be a mock trial of a case of cardiopulmonary impairment in an industrial worker, which will be presented on Friday afternoon, December 7.

Further information may be obtained by writing the American College of Chest Physicians, 112 E. Chestnut Street, Chicago 11, Illinois.

Dr. Eugene S. Brown, who has been engaged in the practice of medicine at Summersville, has accepted appointment as Chief of the Out-Patient Service at the Veterans Administration Hospital in Clarksburg.

H. R. 10 Signed Into Law By President Kennedy

President Kennedy signed into law H.R. 10 permitting physicians and other self-employed persons to take a federal income tax deduction for private pension plans.

The President signed the legislation less than six hours before the midnight October 10 deadline that he had to act on the measure. If he had not signed it by then, it would have become law without his signature. It appeared certain that a presidential veto would have been overridden.

Physicians represent less than three per cent of the self-employed who could benefit under the new law.

Enactment of the legislation into law climaxed a 12-year battle in Congress. The House passed it twice, in 1958 and 1959, but it died each time in the Senate with adjournment.

This year the House passed it with a 361-0 vote. The Senate vote was 70 to 8.

The new law authorizes a self-employed individual, such as a physician, to contribute up to 10 per cent of his earned income or $2,500, whichever is less, toward a retirement plan, provided he includes all of his employees with three or more years of service under the plan. A tax deduction of half of the contribution to the self-employed person's retirement plan would be allowed.

The contributions made on behalf of employes would be fully tax deductible.

The measure prohibits drawing on the retirement funds without penalty before age 59½, except in case of disability or death.—AMA Washington Office.

Mrs. John W. Hash Honored By AMA Auxiliary

Mrs. John W. Hash of Charleston has been named Eastern Regional Chairman of the American Medical Political Action Committee of the Woman's Auxiliary to the American Medical Association. The appointment was made by Mrs. William G. Thuss of Birmingham, Alabama, Auxiliary President.

Mrs. Hash attended a meeting of the new five-member committee in Chicago, October 1-2. The session was held in connection with the 19th annual conference of state presidents, presidents elect, national officers and chairmen of various committees.

National Society Meets

The Annual Meeting of the National Society for Crippled Children and Adults will be held at the Hotel Fountainebleau in Miami Beach, Florida, November 16-20.

Rehabilitation authorities from the United States, Canada and 15 Caribbean countries will attend the meeting to exchange ideas and discuss the newest techniques in the care, treatment and rehabilitation of crippled children and adults.

State Director of Health Stresses Need For Early Flu Shots

The advent of fall brought words of caution from State Director of Health N. H. Dyer. Writing in the Health Department's weekly publication, "State of the State's Health," Doctor Dyer called for early innoculations to prevent a predicted outbreak of Asian Flu and stressed the need for persons employed in medical and health fields to provide themselves with this protection.

Early autumn also is the time for checking out the safety of home heating units and automobile exhaust systems, he noted. "At this time of the year we are cleaning and adjusting our furnaces, but the flues leading to the chimney are too often not considered. Corrosion or loose connections may permit the escape of gases and periodic examinations are necessary." Similarly, space heaters, hot water heaters and other portable appliances which burn a fuel for operation must be properly vented, the Director of Health warned.

"The automobile engine is another important generator of carbon monoxide and cold weather motoring curtails good ventilation." Doctor Dyer suggested that car owners have exhaust sytsems checked and leaking sections repaired and also reminded West Virginians to keep a window open when the engine is running and to avoid operating the automobile in a closed area.

Restrict Type III Oral Polio Vaccine

Considering the recommendations of the Surgeon General Luther L. Terry and the special oral polio vaccine advisory committee, he made several suggestions to local health officers.

The non-epidemic use of Type III oral vaccine should be restricted to pre-school and school age children. "Plans and programs using Types I and II oral vaccines for all age groups should continue. Type III vaccine may be used among adults in high risk groups which would include tourists to hyper-endemic areas and persons residing in epidemic areas; however, there is now no threat of an epidemic in our state. We do wish to affirm the desirability of restricting mass oral vaccine use to the late fall, winter and spring."

Doctor Dyer also called on health personnel in every county to take responsibility for clarifying the safety of Salk vaccine and stress the necessity for increasing its use. "We should again encourage early and complete reporting of suspected polio cases," he stated. "Specimens should be sent to the State Hygienic Laboratory as early as possible and physicians should obtain information on preparing and submitting specimens from their local health departments."

Birth Rate Declines Again

The State Director of Health also released the annual compilation of public health statistics for West Virginia, noting that over 38,000 live births were recorded in 1961, with a rate of 20.9 births per 1,000 population. He said that "this rate, which has decreased each year since an all-time high in 1947, is currently lower than it was during most of the depression days and contrasts with 23.4 rate for the United States as a whole."

Nearly 97 per cent of the children were delivered in hospitals and there was a physician in attendance in almost 99 per cent of the cases. "We are proud that the infant mortality rate has decreased from 32.3 a decade ago to the current figure of 26.5," Doctor Dyer said, but noted that illegitimate births are slowly increasing with a figure of 6.8 per cent in 1961.

"Deaths remain more or less constant at a rate of 9.7 per 1,000 population for the past two years, which is fairly consistent with the national rate." The median age of death was 68.9 years. West Virginia's leading causes of death, diseases of the heart, cancer, vascular lesions affecting the central nervous system, and accidents, match the nation's leading causes in frequency and rate.

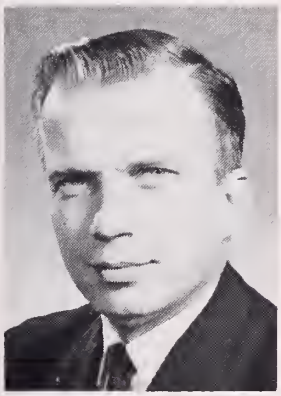
Named to Rehabilitation Post

Dr. Kenneth L. Clark of Charleston has been named full-time chief consultant of the Disability Determination Section of the West Virginia Division of Vocational Rehabilitation. He succeeds Dr. Ralph H. Nestmann of Charleston, who resigned.

Dr. Morris Fishbein was the guest speaker at the banquet held in connection with the Seventh Annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg on Saturday evening, September 15. Shown at the speakers table are, left to right, Dr. S. Elizabeth McFetridge of Shepherdstown; Mrs. Don S. Benson of Moundsville; Mrs. Frank A. Hamilton of Martinsburg; Doctor Benson; Mrs. Thomas H. McGavack and Doctor McGavack of Martinsburg; Dr. and Mrs. Fishbein; Dr. F. A. Hamilton of Martinsburg; Dr. Carolyn McCue of Richmond, Virginia; Dr. Halvard Wanger, Executive Director of the Postgraduate Institute; and Dr. Doris Howell of Durham, North Carolina.

Harry R. Hinton Assigned as New AMA Field Representative

Harry R. Hinton of Chicago recently joined the staff of the Field Service Division of the American Medical Association and has been assigned to West Virginia and several other eastern states. He succeeds John Pompelli, also of Chicago, who served in this capacity during the past 18 months. He has been transferred by the AMA to another assignment on the West Coast.



Harry R. Hinton

John W. Pompelli

Mr. Hinton is a native of St. Charles, Kentucky, and was graduated in 1948 from the University of Kentucky. In 1961, he received a Master of Science Degree in hospital administration from Northwestern University.

He served as administrator of a 110-bed hospital in Madisonville, Kentucky, 1951-54, and in the same capacity at a 450-bed hospital in Louisville, 1954-61. He joined the AMA Field Service Division on April 1, 1961, and several months later accepted appointment as assistant to the director of the AMA Environmental Medicine Division.

During World War II, he served with the United States Army from 1943 to 1946. He volunteered for paratroop duty and served with the 82nd Airborne Division in the European Theatre of Operations, receiving two bronze stars and the Army Commendation Ribbon-Citation for meritorious service.

He is married and the father of three sons and one daughter.

Diabetes Symposium in Washington, D. C.

A symposium on "The Current Aspects of Diabetes" will be sponsored by the Diabetes Association of the District of Columbia at the Washington Hospital Center in Washington, D. C., on December 13.

The speakers will include Drs. Thomas W. Mattingly of Washington, J. M. B. Bloodworth of Madison, Wisconsin, George W. Hamwi of Columbus, Jerome W. Conn of Ann Arbor, Michigan, and Alexander W. Marble of Boston.

Further information concerning the program may be obtained by writing Dr. Adolph Friedman, 1712 Eye Street, N. W., Washington 6, D. C.

56th Southern Medical Assn. Meeting In Miami Beach, Nov. 12-15

Several West Virginia physicians will participate in the scientific sessions planned in connection with the 56th Annual Meeting of the Southern Medical Association which will be held at the Fontainebleau Hotel in Miami Beach, Florida, November 12-15.

Drs. James T. Spencer of Charleston and Albert C. Esposito of Huntington will appear as speakers on the program of the Section of Ophthalmology and Otolaryngology. Doctor Spencer will open the discussion following presentation of a paper on "Congenital Deafness" by Dr. Dekle Taylor of Jacksonville, Florida.

Doctor Esposito, who also serves as secretary of the Section, will discuss a paper which will be presented by Dr. Armstead Hudnell on the subject of "Vomiting Following Cataract Surgery."

Dr. Howard A. Swart of Charleston is the Southern Medical Councilor from West Virginia and Doctor Esposito the Councilor Elect.

Associate Councilors are Doctor Esposito and Drs. Arthur A. Abplanalp and James T. Spencer of Charleston; Thomas H. Blake of St. Albans; and Harold H. Howell of Madison.

Record Attendance Expected

A record attendance of about 7,000 is expected for the four-day meeting which will include a wider range of topics than previous sessions, in addition to expanded scientific closed circuit television programs and three symposia geared to the rapidly changing problems of modern medicine.

A symposium on astromedicine will be conducted by physicians, scientists and members of the armed services who are playing vital roles in space developments. Another will be presented on endocrinology and a third on modern office practices.

21 Scientific Section Programs

The 21 scientific section programs, from anesthesiology to urology, will have as guest speakers internationally known heads of departments in leading medical schools, outstanding professors of medicine, and veteran practitioners in various fields.

Dr. A. Clayton McCarty of Louisville, Kentucky, is president of the Southern Medical Association. The president elect is Dr. Daniel L. Sexton of St. Louis, Missouri.

A featured speaker at the President's Luncheon honoring Doctor McCarty on November 13 will be Dr. Edward R. Annis of Miami, president elect of the American Medical Association.

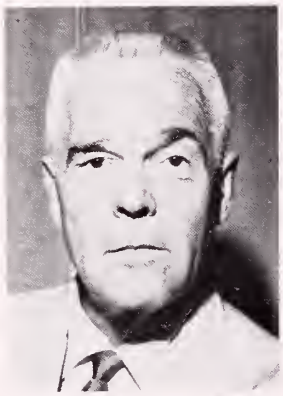
Auxiliary Meeting

The 38th annual meeting of the Auxiliary will be held in conjunction with the meeting of the Association. Mrs. Vernon L. Dyer of Petersburg is the Southern Medical Councilor from West Virginia.

Happiness is not having what you want, but wanting what you have.—Dr. Hyman Judah Schachtel.

Dr. J. Keith Pickens New President Of W. Va. Heart Association

Dr. J. Keith Pickens of Clarksburg was installed as president of the West Virginia Heart Association at the annual meeting held at the West Virginia University Medical Center in Morgantown on September 21. He succeeds Dr. Morris H. O'Dell of Charleston.



J. Keith Pickens, M. D.

Other officers were elected as follows:

Dr. Otis G. King of Bluefield, president elect; Dr. A. C. Thompson of Elkins, vice president; Mrs. Seth Savage of Vienna, secretary (reelected); and Miss Mary Helen Thompson of Charleston, treasurer.

Doctor Pickens presided at the scientific and business sessions held during the meeting. A banquet was held at the Morgantown Country Club on Friday evening.

Atopic Dermatitis Project Proposed For YMCA Asthma Program

The addition of a project on atopic dermatitis to the YMCA Asthma Conditioning Program in Charleston has been proposed for evaluation purposes. The program was organized in 1956 to aid in the rehabilitation of patients with bronchial asthma. Similar programs are now under way in 45 other cities.

The first of several unanswered problems is the relative importance of exercise versus group therapy. The methods of evaluating patients in the program also are inadequate. Some patients have improved in all spheres except bronchial asthma. Others have become free of asthma, but have exhibited anti-social problems which probably require the aid of a psychiatrist.

Dr. Merle S. Scherr of Charleston, one of the founders of the program, said the proposed study could be carried out by including patients with atopic dermatitis, of both sexes, between the ages of seven and fourteen years, who have had proper allergy management. He said that in this way, an attempt would be made to evaluate the effect of the emotional group activities as well as the effect of exercise, if any, on their atopic dermatitis. This project, he said, would add considerably to the understanding of certain problems found in allergic patients.

Allergy Meeting in New York City

The 19th annual congress and graduate instructional course, sponsored by the American College of Allergists, will be held at the Americana Hotel in New York City, March 24-29.

Further information may be obtained by writing Dr. John D. Gillaspie, 2141 14th Street, Boulder, Colorado.

New Association Members

Dr. Robert C. Gow, The Golden Clinic, Elkins (B-R-T). Doctor Gow was born in Pittsburgh and was graduated from the University of Pittsburgh. He received his M. D. degree in 1946 from the University of Pittsburgh School of Medicine, and served an internship at the Medical Center in Pittsburgh, 1946-47. He served a residency and also had postgraduate work at the Children's Hospital in Pittsburgh, 1947-51. He served as a Captain in the Medical Corps of the United States Army, 1951-54, and was formerly located in Evansville, Indiana. His specialty is pediatrics.

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Dr. James H. Nelson, Jr., 114½ Summers street, Charleston (Kanawha). Doctor Nelson was born in Hinton and was graduated from West Virginia State College. He received his M. D. degree in 1932 from Meharry Medical College, Nashville, Tennessee, and interned at St. Agnes Hospital, 1932-33. He also had postgraduate work at Temple University and the New York Postgraduate School of Medicine. He was licensed to practice in West Virginia in 1937 and practiced in Denmar prior to locating in Charleston. He is engaged in general practice.

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Dr. Benjamin G. Velasquez, 4931 MacCorkle Avenue, S. W., South Charleston (Kanawha). Doctor Velasquez, a native of Taytay, Rizal, Philippines, received his M. D. degree from the University of Santo Tomas in the Philippines. He interned at Kanawha Valley Hospital in Charleston, 1956-57, and served residencies at Charleston Memorial and Thomas Memorial Hospital in South Charleston, 1957-61. His specialty is pediatrics.

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Dr. E. C. Voss, Jr., The Wheeling Clinic, Wheeling (Ohio). Doctor Voss was born in Buffalo, New York, and received his M. D. degree in 1950 from the University of Buffalo School of Medicine. He interned at Detroit Receiving Hospital, 1950-51, and served a residency at the State University Hospital of Iowa, 1953-58. He served as a Captain in the Medical Corps of the United States Army, 1950-53, and was previously located at La Crosse, Wisconsin. His specialty is general surgery.

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Dr. Herbert E. Warden, WVU Medical Center, Morgantown (Monongalia). Doctor Warden was born in Cleveland, Ohio, and received his M. D. degree in 1946 from the University of Chicago School of Medicine. He interned at the University of Chicago Clinics, 1946-47, and served a residency at the University of Minnesota, 1951-56. He served as a Lieutenant in the Medical Corps of the United States Navy and served on the staff of the University of Minnesota Hospitals prior to joining the faculty at the University. His specialty is general and thoracic surgery.

Public opinion is everything. With public sentiment nothing can fail; without it, nothing can succeed. Consequently, he who moulds public opinion goes deeper than he who enacts statutes or pronounces decisions.—Abraham Lincoln.

Dr. Greeneltch To Speak at AMA Meeting in Los Angeles

Dr. D. E. Greeneltch of Wheeling will participate in the Fifth Annual Medical Services Conference which will be held in conjunction with the 16th Annual Clinical Meeting of the American Medical Association in Los Angeles, California, November 25-28.

D. E. Greeneltch, M. D.

Doctor Greeneltch, who is immediate past president of the State Medical Association, will be among the speakers on the program that will be devoted to the subject of "Kerr-Mills in Action—1962." He will discuss the implementation and operation of the MAA program in West Virginia during the past two years.

The conference is held annually and is sponsored by the AMA Council on Medical Service.

State Delegates to Attend Meeting

Dr. Charles A. Hoffman of Huntington and Dr. Frank J. Holroyd of Princeton are the official delegates from the State Medical Association and will attend all sessions of the AMA House of Delegates. Doctor Greeneltch and Dr. Thomas G. Reed of Charleston are the alternate delegates.

More than 12,000 persons, half of them physicians, are expected to attend the meeting. General headquarters for the meeting will be the Biltmore Hotel, where the House of Delegates will meet several times during the meeting. Scientific sessions, general registration and scientific and industrial exhibits will be held in the Shrine Auditorium.

Scientific Program

Dr. Wilbur Bailey of Los Angeles, chairman of the committee on local arrangements, has announced that more than one hundred scientific papers will be presented during the four-day meeting. In addition, more than two hundred industrial and scientific exhibits will be on display in the Auditorium.

One of the features of the meeting will be a program on viral hepatitis which will present the most recent findings in studies of the only infectious disease which has shown an increase in the United States in recent years. One of the speakers will be Dr. Joseph D. Boggs of Chicago, a member of the faculty at the Northwestern University School of Medicine, who presented a paper at the 1961 AMA meeting reporting on studies that indicated an approach to developing a hepatitis vaccine.

A program devoted to aerospace medicine will feature papers by several physicians who have a leading role in the astronaut program, and also will include presentations by medical directors of an airline and an aircraft manufacturer regarding medical problems encountered in commercial aviation.

Air pollution will be studied from various aspects, with special emphasis on air pollutants that may cause physical ailments that require medical treatment.

Two units of the program will deal entirely with cancer, one on the etiology and pathogenesis of cancer and the other on new developments in chemotherapy for cancer. In addition, a number of papers on other aspects of cancer will be presented on several other segments of the program.

MLB Licenses 41 Physicians To Practice In State

The Medical Licensing Board has licensed 41 physicians as the result of the examination at the summer meeting held in Charleston, July 23-25, 1962. The following physicians were licensed to practice medicine in West Virginia:

Burkhard, Ernst Albert, Logan
Carte, Estol Taylor, Jr., St. Albans
Curry, William Lake, Richmond, Virginia
Dawson, Robert Lloyd, St. Petersburg, Fla.
Dawson, Wallace Lantz, Kingwood

Dawson, William Sidney, Jr., Freemont, N. C.
de Armas, Francisco Maximiliano, Beckley
Fidler, Robert Young, Richmond, Virginia
Gaal, Geza Zoltan, South Charleston
Galuszka, Albin Adolph, Clarksburg

Ghersi, Juan Carlos, Huntington
Giustini, Fernando G., Fairview, Mass.
Glover, Douglas Dennis, Atlanta, Georgia
Golji, Hossein, Elkins
Hicks, Donald Lee, Oklahoma City, Okla.

Huet, Raul, Weston
Janicki, Thomas Joseph, Charleston
Johnson, William Waldo, Charleston
Kennedy, Harry Greene, Jr., Charleston
Marchesi, Carlo, Webster Springs

Maxey, Stephen Stone, Charleston
Mazzocco, Victor Eugene, Morgantown
Meador, James Carr, Jr., Charleston
Miller, James Barry, Gauley Bridge
Pagan-Lugo, Jose Angel, Man

Pasquale, Samuel Anthony, Williamson
Poole, Thomas Robert, Charleston
Power, Curtis Garland, Jr., Martinsburg
Preisman, Robert Arthur, Charleston
Repaire, John Richard, Flint, Michigan

Russell, Donald Eugene, Middletown, Pa.
Snyder, James Leigh, Crumpler
Spiggle, Wayne Campbell, Jr., Morgantown
Sponaugle, Harlan Dale, Franklin
Steunebrink, Sjoerd, Elkins

Tolley, Gary Maurice, Huntington
Van Gilder, John Corley, Sutton
Wanger, William Halvard, Shepherdstown
Wotring, James William Jr., Richmond, Va.
Yurko, Anthony Andrew, Jr., Columbus, Ohio
Zambos, Nicholas D., Beckley

Rehabilitation is making a person aware of his potential and then providing him with the means of attaining that potential.—W. Scott Allen, "Rehabilitation: A Community Challenge," John Wiley & Sons, Inc.

Commentary on Doctor Ramsey And Stonewall Jackson

An article concerning the life of Dr. John Walter Ramsey, a Clarksburg physician, was published in the July issue of *The Journal*. The author, Clinton F. Israel, has received several letters concerning Doctor Ramsey. An interesting commentary is the letter of Mr. George M. Osborn of Geneva, Illinois, who as a young man was a frequent visitor to Doctor Ramsey's office and probably was the last living person to hear from Doctor Ramsey the following story of the death of Stonewall Jackson:

"That story was of the shooting of General Thomas Jonathan (Stonewall) Jackson, by his pickets, on the evening of May 2nd, 1863. The doctor told the story in much detail, and all that I recall of it checks, in most respects, with the many published accounts I have read. In one respect, however, Doctor Ramsey's story differs from any of the accounts that I have read.

"The usual accounts of General Jackson's injury and death recount that on the evening of May 6th he appeared to Dr. Hunter H. McGuire, medical director of Jackson's army, to be in satisfactory condition, so that Doctor McGuire, very tired after his long vigils, went to bed in a room adjoining General Jackson's, leaving the General's body-servant, Jim, on watch. Some hours after Doctor McGuire went to bed, Stonewall called Jim, and complained of stomach cramps, directing Jim to apply a wet towel to his abdomen. Jim remonstrated, and wanted to awaken Doctor McGuire, but the General forbade this and ordered Jim to procure the towel at once, which Jim then did. When in the early morning Doctor McGuire awoke and attended the General, he observed what must have been the signs of well-advanced post-operative pneumonia, and he at once called together a number of the physicians he had gathered at the house at Guiney Station to consult with him. But nothing now could halt the progress of the disease, and Stonewall 'crossed over the river' on the afternoon of the 10th of May, 1863.

"Doctor Ramsey's account, as told to me, differs from the foregoing in one important detail. 'Stonewall was,' Doctor Ramsey said, 'a fanatic' in two matters: he was a religious fanatic, and he was fanatically devoted to cold baths.' Before Doctor McGuire left him, on the evening of May 6th, he asked the doctor if he might have Jim, his body servant, give him a cold bath. 'No General,' Doctor McGuire replied. 'A cold bath now might well kill you, Sir.'

"Not long after Doctor McGuire had gone to sleep, however, the General called Jim and directed him to soak a sheet in a bucket of cold water, wring it out, and wrap it around him. Jim objected as sturdily as he could, but was overridden, and so did as ordered. When, next morning, the onset of pneumonia was evident, Doctor McGuire asked a number of the physicians as to their opinions. When that question was asked Doctor Ramsey—I recall that Doctor Ramsey used the word 'prognosis,' the first time I had ever heard that word used—he said that his reply to Doctor McGuire was 'He will die on the third day, Sir.' I well recall the sentence that followed: 'And he died; on the third day.' There was, of course, in Doctor Ramsey's voice, no pride in having been right—only sadness at what he considered the unnecessary death of the great leader.

"I do not recall when it was that I last saw Doctor Ramsey, but it was some time before I left Clarksburg for Morgantown in 1908. He had been moved from the house on Second Street to the home of a woman who was a former patient of his, far up the hill, southwards, on Second Street; and it was there, probably, that he died.

"None of the accounts of General Jackson's death that I have read mentions Doctor Ramsey as one of the consulting doctors with Doctor McGuire; but Doctor Ramsey was in all things a careful and reliable man, and I attribute the omission of his name as possibly due to the sketchy military history of the Confederacy."

Relocations

Dr. J. R. Hatfield, who has practiced in Holden for the past six years, has relocated his practice in Gilbert and his mailing address is Box 218.

* * * *

Dr. Robert G. Smith, who recently completed a residency in orthopedic surgery at the Bowman-Gray School of Medicine, has located in Huntington where he is associated with Dr. James A. Heckman.

* * * *

Dr. Edward Gliserman, who has been engaged in general practice in Montcoal, has moved to Shinnston and has offices at 1 Columbia Road.

PG Course on Orthopedics

A postgraduate course on "Orthopedics in General Practice" will be presented at the Medical College of Georgia in Augusta, December 4-6. The course will emphasize the diagnosis and conservative treatment of orthopedic disease and injury, primarily in the ambulatory patient.

Registration fee for the three-day meeting is $50. Further information may be obtained by writing Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta.

New Film on Respiratory Physiology

A new teaching film on "Chemical Balance Through Respiration" has been produced by the National Foundation in cooperation with Dr. James L. Wilson and his associates in the Department of Pediatrics at the University of Michigan School of Medicine.

The 20-minute film illustrates some basic facts regarding respiratory physiology with particular emphasis on gas exchange between lungs and tissue and the maintenance of a stable hydrogen ion concentration through breathing and the buffering action of the blood.

The film is available for showings before county medical societies and may be obtained by writing the National Foundation, 800 Second Avenue, New York 17, New York.

Washington Postgraduate Seminar Will Be Held In Caribbean

The Washington Postgraduate Medical Seminar will be held aboard the Holland American Line Flagship Rotterdam, January 5-20, 1963, in the Caribbean.

An outstanding group of educators from the Washington, D. C., schools of medicine and hospitals will present a program pertinent to the practicing physician, stressing diagnosis and treatment.

The Rotterdam will depart from New York City on Saturday, January 5, and return to that port on Sunday, January 20. Stops will be made at St. Thomas, LaGuaira, Curacao, Kingston and Nassau.

The registration fee is $25 for physicians. Members of the American Academy of General Practice attending the Seminar are eligible for 30 hours of Category One Credit. Further information on the Seminar and cruise may be obtained by writing the Allen Travel Service, 565 Fifth Avenue, New York 17, New York.

Medical Meetings, 1962-63

The following is a partial list of national, state and district medical meetings scheduled for 1962-63:

1962

Nov. 2-4—ACP Regional Meeting, White Sul. Springs.
Nov. 12-15—Southern Medical, Miami Beach, Fla.
Nov. 24-25—ACCP, Ambassador Hotel, Los Angeles.
Nov. 26-29—AMA Clinical Meeting, Los Angeles.

1963

Apr. 17-20—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
May 3-4—W. Va. Soc. Med. Technologists, Clarksburg.
May 24-26—W. Va. Chapter AAGP, Charleston.
June 16-20—AMA Annual Meeting, Atlantic City.
Aug. 22-24—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Oct. 9-11—W. Va. Hospital Association, Wheeling.
Oct. 27-31—ACS Clinical Congress, San Francisco.
Dec. 1-4—AMA Clinical Meeting, Portland, Ore.

Need a Physician?

Communities in rural areas in West Virginia that are interested in securing a physician may have their requests published in the classified section of *The West Virginia Medical Journal*. Interested persons should submit the population of the area in which the physician is needed and send along a descriptive sentence of their requirements and advantages of practice.

Such information will be published in *The Journal* in the hope that physicians in the state may have medical colleagues who might be interested in the practice of rural medicine in West Virginia.

A listing of physicians wishing to locate in West Virginia will also be published, provided they submit their qualifications to the headquarters offices of the State Medical Association. This service will be provided to communities and physicians without charge.

Medico-Legal Trial Demonstration At Medical Center, Nov. 16

A Medico-Legal Trial Demonstration will be held at the West Virginia University Medical Center in Morgantown on Friday afternoon, November 16, under the auspices of the West Virginia Trial Lawyers Association and the WVU College of Law and School of Medicine.

Dr. Byron M. Bloor of Morgantown, Professor of Neurological Surgery at the School of Medicine, will be the medical speaker. He will be assisted by Drs. G. Robert Nugent and John W. Nelson of the same department.

The legal speakers are John J. Lane of Charleston, president of the National Association of Claimant's Attorneys; Stanley E. Preiser of Charleston, president of the West Virginia Trial Lawyers Association; Robert O. Ellis, Jr., of Huntington; and Seymour Sikov of Pittsburgh.

The Hon. Frank C. Haymond of Fairmont, judge of the West Virginia Supreme Court of Appeals, will preside at the demonstration. Dr. Clark K. Sleeth, Dean of the School of Medicine, and Professor W. O. Morris of the WVU College of Law, are in charge of arrangements.

W. Va. Dietetic Association Meets In Charleston, Nov. 9-10

Several physicians will appear on the program at the annual meeting of the West Virginia Dietetic Association at the Daniel Boone Hotel in Charleston, November 9-10.

Dr. J. Paul Aliff and Dr. Margaret T. Ross, both of Charleston, will be members of a panel which will discuss "Nutrition Quackery" at the opening session on November 9. Dr. Merle S. Scherr of Charleston will present a paper on "A Practical Approach to Food Allergy" at the closing session on Saturday morning, November 10.

New Film Available

A new film entitled "PKU Mental Deficiency Can Be Prevented" is available for showings at meetings of component societies.

The 14½ minute black and white film presents the case histories of two siblings, both with phenylketonuria (PKU)—an inborn metabolic error, which can lead to severe and permanent mental retardation. It reviews the biochemistry, genetics, symptoms, diagnosis and management of PKU.

The film may be obtained by writing to the Medical Film Department, Ames Company, Inc., Elkhart, Indiana.

Spring Congress in Roanoke

The 36th Annual Spring Congress in Ophthalmology and Otolaryngology and Allied Specialties, sponsored by the Gill Memorial Eye, Ear, and Throat Hospital, will be held in Roanoke, Virginia, April 1-5, 1963.

Six West Virginia delegates attended the annual meeting of the American Association of Medical Assistants in Detroit, September 25-30. The State Association and Kanawha County Chapter each received second-place trophies for the greatest increase in membership in the past year. Seated, left to right, Mrs. Mary Ellen Kessler of Beckley and Mrs. Bette Hicks of St. Albans, state president. Standing: Mrs. Juanita Rauch of Parkersburg; Mrs. Eulalia Hanly of Charleston, president elect; Mrs. Lee Grow of Parkersburg and Mrs. Dymple Halstead of Beckley.

Blue Shield Enrollment Passes 50-Million Member Mark

The 76 Blue Shield Plans located in North America surpassed the 50 million member mark in their enrollment as of June 30, 1962, the National Association of Blue Shield Plans announced recently.

Total membership in Blue Shield at the end of June reached 50,047,782, as a result of a net gain of 795,160 new members during the second quarter of 1962. The June, 1962 figure represents an increase of almost two million members over the June, 1961 enrollment mark.

The national association reported that Blue Shield now covers one out of every four Americans, and 15 per cent of the total Canadian population.

Thirteen Blue Shield Plans have enrolled more than 40 per cent of the population in the areas they serve. Among them, the District of Columbia Blue Shield Plan has enrolled four out of every five residents in that area; Rhode Island Blue Shield has more than 68 per cent of the state's population covered; Rochester, N. Y., has nearly 66 per cent of its area enrolled; and the Delaware Plan has almost 60 per cent of the state enrolled.

Three Blue Shield Plans registered significant enrollment gains during the second quarter. The Toronto Blue Shield Plan added nearly 90,000 new members during the period; Massachusetts Blue Shield reported a gain of more than 77,000 members; and the New York City Plan registered a 51,000 gain.

The national association also noted that there were 19,798,391 contracts in force as of June 30, with the number of members per subscriber contract averaging 2.53 members.

Nine State Physicians Inducted As Fellows of ACS

Nine West Virginia physicians were inducted as Fellows of the American College of Surgeons in cap and gown ceremonies held during the 48th Annual Clinical Congress of the Organization in Atlantic City, October 15-19.

Founded in 1913, the ACS has grown in 49 years' time from a founding group of 450 to a total membership of approximately 25,000 in 79 nations.

The following state physicians were inducted: B. B. Richmond, Beckley; Robert W. Neilson, Jr., Bluefield; William E. Lawton, Jr., and Carrel M. Caudill, Charleston; Bill R. Blackburn, Elkins; H. Carl Wasson, Jr., Huntington; D. Franklin Milam and Herbert E. Warden, Morgantown; and Edward C. Voss, Jr., Wheeling.

Five Medical Publications Cited For Distinguished Service

Five medical publications were cited by the American Medical Writers Association for "distinguished service in medical journalism to the medical profession" during the recent annual meeting of that organization in Washington, D. C.

The journals honored were "Archives of Internal Medicine," "Bulletin of the San Diego County Medical Society," "Medical Science," "New England Journal of Medicine," and the "New York State Journal of Medicine."

Dr. Richard H. Orr, AMWA President, presided at the annual dinner at which the awards were presented. Dr. George G. Stilwell of Rochester, Minnesota, served as chairman of the awards committee.

Uniformity in State Drug Laws

If the city of New York were to attempt to regulate drugs in county-wide channels of commerce, and other cities and states were to follow this example, a chaos of conflicting local and state requirements would be imposed on drug manufacturers throughout the country.

This would be reflected in the cost of the drugs to the users. It would burden the industry in such a way as to make trade practically impossible. For many years we have supported efforts to achieve uniformity of food and drug legislation so as to give the consumer the greatest benefit of all advances and impose the least burden on industry.—Leona Baumgartner, M. D., New York City Health Commissioner.

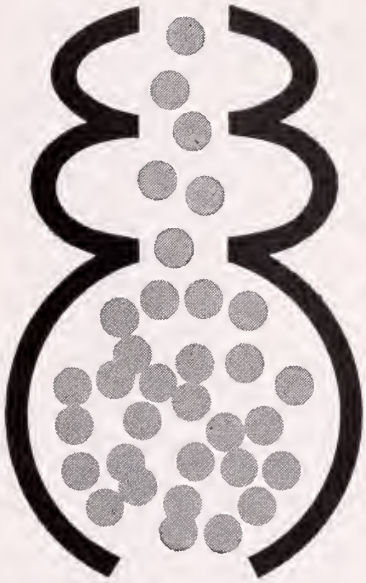
ACP Course in Baltimore

The American College of Physicians will sponsor a postgraduate course in "Endocrinology and Metabolism" at the Johns Hopkins Hospital in Baltimore, November 13-17.

Dr. Samuel P. Asper, Jr., will serve as director of the course and further information may be obtained by writing the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania.

LOMOTIL®

(brand of diphenoxylate hydrochloride with atropine sulfate)



ANTIDIARRHEAL TABLETS and LIQUID

lowers motility / relieves cramping / controls diarrhea

Roentgenographic studies by Demeulenaere[1] established that a single dose of 10 mg. of Lomotil slowed gastrointestinal transit within two hours and that it maintained its decelerating activity for more than six hours.

In diarrhea this lowered propulsion permits a physiologic absorption of excess fluid, lessens frequency and fluidity of stools and gives safe, selective, symptomatic control of most diarrheas. Concurrently, it conserves electrolytes and controls cramping.

Investigators have found the antidiarrheal action of Lomotil not only "excellent"[2] but "efficacious[3] where other drugs have failed. . . ."

DOSAGE: For *adults* the recommended initial dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is under control. Maintenance dosage may be as low as two tablets daily. For *children* daily dosages, in divided doses, range from 3 mg. (½ teaspoonful three times daily) for infants 3 to 6 months to 10 mg. (1 teaspoonful five times daily) for children 8 to 12 years. Lomotil is supplied as unscored, uncoated white tablets of 2.5 mg. and as liquid containing 2.5 mg. in each 5 cc. A subtherapeutic amount of atropine sulfate (0.025 mg.) is added to each tablet and each 5 cc. of the liquid to discourage deliberate overdosage. The recommended dosage schedules should not be exceeded.

NOTE: Lomotil is an exempt narcotic preparation.

Descriptive literature and directions for use detailed in Physicians' Product Brochure No. 81 available from G. D. Searle & Co., P. O. Box 5110, Chicago 80, Illinois.

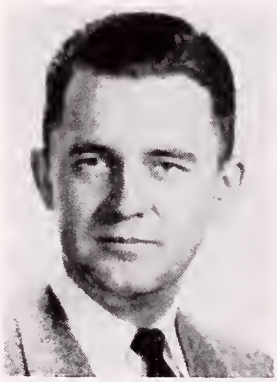
1. Demeulenaere, L.: Action du R 1132 sur le transit gastrointestinal, Acta Gastroent. Belg. 21:674-680 (Sept.-Oct.) 1958.
2. Kosich, A. M.: Treatment of Diarrhea in Irritable Colon, Including Preliminary Observations with a New Antidiarrheal Agent, Diphenoxylate Hydrochloride (Lomotil), Amer. J. Gastroent. 35:46-49 (Jan.) 1961.
3. Weingarten, B.: Weiss, J., and Siman, M.: A Clinical Evaluation of a New Antidiarrheal Agent, Amer. J. Gastroent. 35:628-633 (June) 1961.

G. D. SEARLE & CO.

Research in the Service of Medicine

WVU Medical Center
—News—

DR. Alvin L. Watne has accepted appointment as Associate Professor of Surgery, Chief of the Cancer Committee and Director of the Tumor Clinics at the West Virginia University School of Medicine. Doctor Watne, formerly Associate Chief Cancer Research Surgeon at Roswell Park Memorial Institute in Buffalo, New York, will occupy the Charleston Foundation Chair of Cancer Research. The chair is supported by an annual $10,000 endowment from the foundation established in 1958 by the late Dr. G. B. Capito of Charleston.



Alvin L. Watne, M. D.

Widely known throughout the United States, Doctor Watne brings portions of four research grants with him to the School of Medicine. Two grants from the American Cancer Society total $47,000. The others are from the U. S. Public Health Service and total $34,000.

Doctor Watne's primary interests are in advances in cancer surgery, how cancer spreads in the body, chemical treatment of cancer and the relationship of viruses and immunity to cancer. His main objective at WVU will be research.

He is a native of Dixon, Illinois, and attended the University of Illinois. He received his M. D. degree from the University of Illinois College of Medicine and served in the Medical Corps of the United States Army, 1944-46. He was a Fellow of the American Cancer Society, 1957-58, and is certified by the American Board of Surgery.

Clarksburg Physicians Join Faculty

Dr. Adolfo R. Diaz-Perez and Dr. Firooz Emami, both of Clarksburg, have joined the clinical faculty of the West Virginia University School of Medicine.

Doctor Diaz-Perez, who was appointed Clinical Assistant Professor of Medicine, is a native of Asuncion City, Paraguay, and received his M. D. degree from the National University. He served on the faculty of that institution prior to coming to the United States in 1957 to serve his residency at the University of Virginia Hospital in Charlottesville, Virginia. He is acting chief of the laboratory service at the Clarksburg VA Hospital.

• **Compiled from material furnished by Howard Lewis, Administrative Assistant to the Vice President, West Virginia University Medical Center, Morgantown, West Virginia.**

Doctor Emami, who was named a Clinical Instructor in Medicine, was born in Tehran, Iran. He attended schools in that country and served residencies in Cleveland, Ohio, and New York City hospitals. He recently completed a fellowship in gastroenterology at Lahey Clinic in Boston.

Hospital Adds 55 New Beds

The WVU Hospital recently added 55 beds, increasing those in service to 305. The expansion marks continued development of the 520-bed facility and is due to increasing needs for patient and educational services at the Medical Center.

A six-bed intensive care unit for children is part of the expansion. The other 49 beds will be on the fifth floor of the 10-story hospital. They will be used for neurosurgery, chest disease and neurology patients.

The Hospital opened in August, 1960, when 66 beds were commissioned. Another 132 beds were added in 1961 and 52 have been put into service this year. Plans are to add another 100 beds during 1963 with the full 520-bed capacity to be reached sometime early in 1965.

School of Medicine Enrollment Climbs

The first semester enrollment at West Virginia University reached a record high of 8,320, a gain of 806 students over last year.

The School of Medicine had 229 students, an increase of 51 over the first semester of the 1961-62 academic year. The Graduate School led all colleges and schools with 198 more students than in 1961.

Symposium on Health Sciences Reporting

A two-day Symposium on Health Sciences Reporting will be held at the WVU Medical Center, November 9-10, for members of the press, radio and television in West Virginia.

It is sponsored by the Medical Center and the WVU School of Journalism under a $5,140 grant from the National Science Foundation. The first of its kind in West Virginia, the symposium is specifically aimed toward better reporting in the health or medical sciences fields.

SAINT ALBANS

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Artie L. Sturgeon, Ph. D.

William D. Keck, M. D.
Edward W. Gamble, III, M. D.
J. William Giesen, M. D.
Internist (Consultant)

Don Phillips
Administrator

AFFILIATED CLINICS

Bluefield Mental Health Center
525 Bland St., Bluefield, W. Va.
David M. Wayne, M. D.
Phone:325-9159

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.
Malcolm G. MacAulay, M. D.
Phone: 253-8397

Charleston Mental Health Center
1119 Virginia St., E., Charleston, W. Va.
Phone: 344-3578

Norton Mental Health Clinic
Norton Community Hospital, Norton, Va.
Pierce D. Nelson, M. D.
Phone: 218, Ext. 55 and 56

The Month in Washington

• From the Washington Office of the American Medical Association.

INFLUENCED strongly by the thalidomide incident, Congress approved legislation giving the Food and Drug Administration more control over the prescription drug industry. The Kennedy Administration and Sen. Estes Kefauver (D., Tenn.), chief sponsor of ethical drug legislation, successfully exploited the thalidomide incident after prospects of passage of a strong drug bill waned.

However, they were unable to get all they wanted in the legislation even with the impact on Congress of the widespread publicity about the clinical testing of thalidomide in this country coupled with reports from Europe of births of malformed children by women who had taken the drug during pregnancy.

One Administration proposal rejected by Congress would have given the Secretary of Health, Education and Welfare authority to require physicians to report directly to him on their clinical tests with new drugs.

Efficacy Provision

The new law empowers the FDA to require "substantial evidence" of the efficacy, as well as safety, of new drugs before licensing them for marketing. The AMA had warned Congress that this might lead to a test of relative efficacy which could result in potentially-helpful drugs being barred from sale. The AMA contended that the old FDA requirement that a drug live up to its label claims was a sufficient test of effectiveness.

The Pharmaceutical Manufacturers Association also warned that drug research might slow down as a result of the new law.

"Some provisions of the new law may not be helpful to the public," the PMA said. "In fact, unless there is the wisest administration of the law harm can be done. For example, medical research may slow down and the costs of medications may increase."

Physicians will be required to get the consent of the patient, or a close relative, for treatment with experimental drugs except in instances where the physician feels that it would not be feasible or would be contrary to his professional judgment. Consent already is a part of the code of ethics of the American Medical Association.

Some other major provisions of the new law: (1) Authorizes the FDA to swiftly suspend any drug which it suspects is dangerous; (2) Requires that the generic name of a drug be printed on the label in type half as large as that for the trade name; (3) Extends the time during which FDA may review a new drug application before it must be approved or disapproved; (4) Authorizes the HEW Secretary to establish generic names for new drugs; (5) Authorizes the HEW Secretary to prevent testing of drugs on humans if he determines there has not been sufficient preclinical testing; and (6) Requires batch certification of all antibiotics.

Vaccination Programs

Congress passed a bill authorizing a $36 million three-year program for federal aid for intensive vaccination programs against polio, diphtheria, whooping cough and tetanus. The vaccination campaigns are to be aimed primarily at children less than five years old. The U. S. Surgeon General was given broad authority in deciding the amount and terms of federal grants under the program.

Grants will be made to states or, when approved by state officials, to cities or other local governmental units.

Also on the immunization front, a Special Advisory Committee twice recommended to the Public Health Service that Type III oral polio vaccinations be continued for pre-school and school age children but not for adults for the time being.

The Public Health Service accepted the recommendation and urged that communities proceed with planned mass vaccination campaigns using Type III for children. But some communities decided to hold up their mass immunization programs at least temporarily or to suspend Type III doses for children, as well as adults.

The Advisory Committee first made its oral polio vaccine recommendation at an emergency meeting on September 15. The meeting was called after Canada suspended use of oral polio vaccine. The Health Ministry action in Canada, where all three types of the oral vaccine had been given in one dose, was prompted by the occurrence of a few cases of Type III polio. The three types of vaccine are given in separate doses in this country.

There also were at that time a few Type III cases reported in this country among adults who had taken the oral vaccine.

Put your low-back patient back on the payroll

Soma relieves stiffness —stops pain, too

YOUR CONCERN: Rapid relief from pain for your patient. Get him back to his normal activity, *fast!*

HOW SOMA HELPS: Soma provides direct pain relief while it relaxes muscle spasm.

YOUR RESULTS: With pain relieved, stiffness gone, your patient is soon restored to full activity—often in days instead of weeks.

This was demonstrated by Kestler in a controlled study: average time for full recovery was 11.5 days with Soma, 41 days without Soma. (J.A.M.A. 172:2039, April 30, 1960.)

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only in higher dosages. Soma is available in 350 mg. tablets.
USUAL DOSAGE: 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

SOMA®

(carisoprodol, Wallace)

Wallace Laboratories, Cranbury, New Jersey

Obituaries

OSCAR BERNARD BIERN, M. D.

Dr. Oscar Bernard Biern, 71, of Huntington, died on October 10 at a hospital in that city.

Doctor Biern was born in Huntington, September 27, 1891, and attended public schools in that city. He attended the University of Michigan and received his M. D. degree from the University of Virginia School of Medicine in 1916.

During World War I, he was a member of the Royal Army Medical Corps of the British Army. Doctor Biern was the first American commissioned abroad and later received the British Military Cross. He was released with the rank of Captain.

Doctor Biern was the founder and twice president of the West Virginia Heart Association and a former member of the West Virginia Medical Licensing Board.

He was an honorary life member of the Cabell County Medical Society, West Virginia State Medical Association, American College of Physicians and the American Medical Association.

Besides his widow, he is survived by a son, Dr. Robert Biern, a Lieutenant in the Medical Corps of the United States Navy and stationed at Corpus Christi, Texas.

* * * *

ROBERT WALDORF FISHER, M. D.

Dr. Robert Waldorf Fisher, 82, of Morgantown, a practicing physician in that city for more than half a century, died on October 5.

Doctor Fisher, a native of Baltimore, was a graduate of Baltimore Polytechnic Institute and he received his M. D. degree in 1903 from the University of Maryland School of Medicine. He was licensed to practice in West Virginia in 1904.

He opened his practice in Morgantown in 1904 after serving an internship and residency at University Hospital in Baltimore. Doctor Fisher served as an instructor at the two-year School of Medicine at West Virginia University, 1913 to 1920, except for a one-year tour of military duty.

During World War I, he was in the Medical Corps of the United States Army and served as an instructor in the School of Military Medicine at Camp Greenleaf and Fort Oglethorpe, Georgia, in 1918. He was released with the rank of First Lieutenant.

Doctor Fisher was an honorary life member of the Monongalia County Medical Society, the West Virginia State Medical Association and the American Medical Association.

EDGAR FRANK HEISKELL, M. D.

Dr. Edgar Frank Heiskell, 71, of Morgantown, died of burns suffered on October 8 at his home in that city.

Doctor Heiskell was born in Davis, Tucker County, on December 30, 1890, son of Neil C. and Winifred Powell Heiskell. He attended West Virginia University and received his M. D. degree in 1918 from the Loyola University School of Medicine in Chicago.

During World War I, he served in the Medical Corps of the United States Army. From 1919 to 1922, Doctor Heiskell served an internship and residency in surgery at Chicago hospitals before returning to Morgantown to open his practice.

He was the founder of Heiskell Memorial Hospital in Morgantown. It was sold in 1950 and is now known as Vincent Pallotti Hospital.

Doctor Heiskell was an honorary life member of the Monongalia County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by two sons, Dr. E. F. Heiskell, Jr., of Morgantown, and Neil J. Heiskell of New York City; one daughter, Mrs. John L. Wildman of Morgantown; a brother, Powell C. Heiskell of Morgantown; and one sister, Mrs. Bess H. Overstreet of Washington, D. C.

* * * *

WILLIAM KNAPP MACKEY, M. D.

Dr. William Knapp Mackey, 73, of Chesapeake, Ohio, died on September 24 at his home in that city.

Doctor Mackey, who practiced for a number of years in Huntington, was born in Woodruff, West Virginia, son of the late John and Florence Knapp Mackey.

He was graduated from Bethany College and received his M. D. degree from the University of Maryland School of Medicine in 1920. He was licensed to practice in West Virginia that same year.

Doctor Mackey was a former member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by a daughter Miss Mary Belle Mackey, and two sons, William J. Mackey and Charles W. Mackey, all of Chesapeake; a brother, Melvin Mackey of Parkersburg; and three sisters, Miss Julia Mackey and Mrs. Carl McCracken of Parkersburg; and Mrs. William Rupp of Cameron.

* * * *

BENJAMIN LEWIS PETTRY, M. D.

Dr. Benjamin Lewis Pettry, 85, of Dorothy, Raleigh County, died at his home in that community on September 30.

Doctor Pettry received his M. D. degree from the University of Louisville School of Medicine in 1907 and practiced 45 years in the Dorothy area prior to his retirement.

He was a former member of the Raleigh County Medical Society, the West Virginia State Medical Association and the American Medical Association.

His only survivor is his widow, Mrs. Ethelyn Russell Pettry.

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County Societies

BARBOUR-RANDOLPH-TUCKER

Doctor Neil M. McFadyen of Weston was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker County Medical Society which was held in Philippi on September 20.

Doctor McFadyen, who is superintendent of Weston State Hospital, discussed "Mental Institutions, Their Changing Concepts and Problems." He said that there were 2300 patients in the 2400-bed hospital, with only 13 physicians caring for same.

He said there is a need for an additional 27 staff physicians, 146 psychiatric nurses and 21 social workers. At the present time, he reported, there are only two social workers and sixteen nurses.

Doctor McFadyen said the average daily cost of caring for a mental patient in the United States is $10, while the Weston State Hospital is allowed $2.74 per patient for daily care. He also stated that 50 per cent of the patients admitted are geriatric cases, many of whom should not be in a mental institution and could be cared for in some other type of facility.

He also cited the need for outpatient mental health clinics to aid patients when they are discharged and returned home.—A. Kyle Bush, M. D., Secretary.

CABELL

Ninety-eight members and guests attended a symposium on "Diseases of the Blood and Blood Forming Organs," sponsored by the Cabell County Medical Society and held at the Hotel Frederick in Huntington on September 13.

The following out-of-state physicians participated in the one-day symposium:

Drs. John D. Battle, Jr., of Cleveland, Bertha A. Bouroncle of Columbus, Claus Mayer of New York City, and John J. Will of Cincinnati.

Dr. Jack H. Baur, Chairman of the Symposium Committee, served as moderator.—W. L. Neal, M. D. Secretary.

* * * *

HARRISON

Dr. L. J. Pace of Princeton, President of the West Virginia State Medical Association, discussed major problems facing the medical profession in an address before a joint dinner meeting of the Harrison County Medical Society and Woman's Auxiliary at the Stonewall Jackson Hotel in Clarksburg on October 4.

Doctor Pace urged the participation of physicians in more civic activities in their communities and state and also greater participation in the work of their political parties.

He also discussed measures which will come before the West Virginia Legislature at its regular session opening in January. These include bills for a Medical Examiner's System and improvements in the commit-

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ment laws for the mentally ill. Doctor Pace also expressed the State Medical Association's approval of a request by the State Department of Health for a $500,000 increase in its annual budget.

Dr. Andrew J. Weaver, the president, presided at the meeting. Doctor Pace was introduced by Dr. George F. Evans of Clarksburg, a past president of the State Medical Association and Editor of *The Journal.*

* * * *

MERCER

The regular monthly meeting of the Mercer County Medical Society was held at the West Virginian Hotel in Bluefield on September 17.

Dr. Joe E. McCary, the president, presided at the meeting and at the outset introduced the new president of the State Medical Association, Dr. L. J. Pace of Princeton.

Drs. John J. Mahood and John A. Warden were in charge of the scientific program. Doctor Mahood discussed a case report and Doctor Warden presented a film on cancer detection. The film emphasized that with early examination, diagnosis and suspicion that a successful cure can reasonably be expected.

Dr. N. Allen Dyer, health officer in Mercer County, discussed the oral polio vaccine program and the predicted epidemic of Asian flu this winter.—John J. Mahood, M. D., Secretary.

MONONGALIA

Dr. William E. Anderson was the speaker at the regular monthly meeting of the Monongalia County Medical Society which was held in Morgantown on September 4.

Doctor Anderson, who is Instructor in Medicine at the West Virginia University School of Medicine, presented an interesting paper on "Hepatic Coma."

During the business meeting, the possibility of sending first aid pamphlets to high school students in the county was discussed. It also was recommended that a letter be written to State Senator William A. Moreland concerning proposed changes in the law pertaining to the admission and discharge laws for the mentally ill.

Thirty-one members and three guests attended the meeting.—George A. Curry, M. D., Secretary.

* * * *

WYOMING

Dr. Kenneth G. MacDonald of Charleston was the guest speaker at a meeting of the Wyoming County Medical Society held at the Glass House near Beckley on September 9.

Doctor MacDonald spoke on "Several Complications Following Gastric Surgery," and "Medicare." He was introduced by Dr. Frank J. Zsoldos of Mullens.

Dr. George F. Fordham of Mullens, the president, presided at the dinner meeting.

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19TH ANNUAL CONFERENCE IN CHICAGO

The 19th Annual Conference of State Presidents, Presidents Elect, National Officers and Chairmen of the Woman's Auxiliary to the American Medical Association was held at the Drake Hotel in Chicago, September 30-October 3.

Attending from West Virginia were Mrs. Howard G. Weiler of Wheeling, President of the Woman's Auxiliary to the West Virginia State Medical Association; Mrs. Pat A. Tuckwiller of Charleston, President Elect of the State Auxiliary; and Mrs. John W. Hash of Charleston, Eastern Regional Member of the American Medical Political Action Committee.

Mrs. C. Rodney Stoltz of Watertown, South Dakota, President Elect of the National Auxiliary, presided over the Conference. Each standing committee presented a discussion, panel or speaker. Outstanding speakers included:

Mr. T. C. Peterson, American Farm Bureau Federation; Miss Jeanne Rogers, Woman's Division, U. S. Chamber of Commerce; Lt. Colonel Clarence E. Davis, Jr., faculty member, Industrial College of U. S. Armed Forces; Dr. Howard P. Rome, Mayo Clinic; Dr. George M. Fister, President, American Medical Association; Robert A. Lang, Ph.D., Executive Secretary, Academy of Medicine of Cleveland and Cuyahoga County Medical Society; Kenneth Haagenson, Past President, Public Relations Society of America.

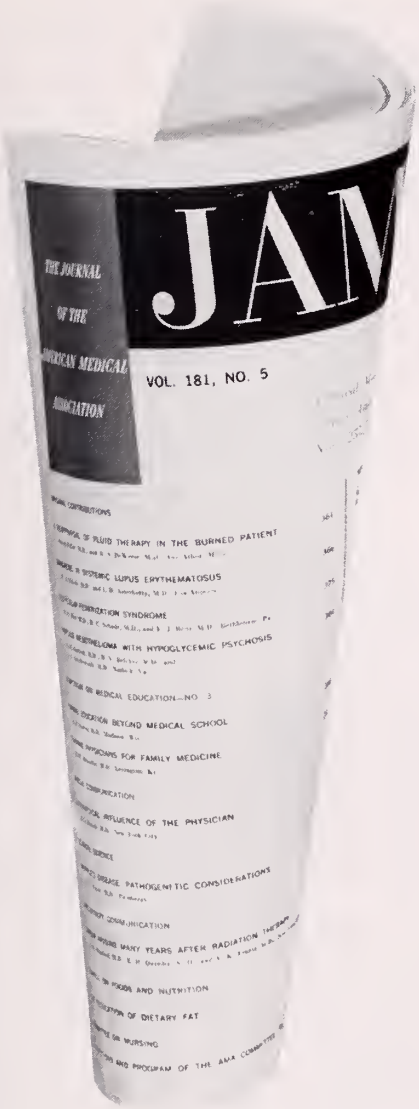
A film showing "Your Health—Your Choice" featuring Dr. Edward R. Annis, President Elect, American Medical Association, was presented by members from the executive offices of the American Medical Association. This film is available for showings through the headquarters offices of the West Virginia State Medical Association.—Mrs. Pat A. Tuckwiller, President Elect.

* * * *

CABELL

The first fall meeting of the Woman's Auxiliary to the Cabell County Medical Society was held at the home of Dr. and Mrs. Charles M. Polan in Huntington on September 25.

The officers of the Woman's Auxiliary to the Kanawha County Medical Society were guests at the meeting. Mrs. Frank M. Peck of Huntington, was chairman and the hostesses were members of the executive board.



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* * * *

GREENBRIER VALLEY

The Woman's Auxiliary to the Greenbrier Valley Medical Society met at the summer camp of Dr. and Mrs. P. E. Prillaman on the Greenbrier River, near Hinton, on September 18.

Mrs. Stuart T. Bray of White Sulphur Springs, the president, presided at the business meeting. Mrs. Robert R. Pittman of Marlinton and Mrs. George L. Lemon of Lewisburg presented reports on the 38th Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association, held at The Greenbrier in White Sulphur Springs, August 23-25.

* * * *

HANCOCK

The program of activities for the coming year was presented at the opening fall meeting of the Woman's Auxiliary to the Hancock County Medical Society at the Williams Country Club in Weirton on September 18.

Mrs. E. M. Clubb, Jr., of Weirton, the president, presided at the business session. Mrs. Myer Bogarad served as hostess for the luncheon.

The program, as presented and approved, included:

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1. Kolodny, A.L.: Dis. Nerv. System *22*:151 (Mar.) 1961.

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Association Education and Research Foundation; and a contribution to the Health Careers Scholarship Loan Fund sponsored by the Woman's Auxiliary to the West Virginia State Medical Association.

* * * *

OHIO

New members were honor guests at the Annual Membership Tea of the Woman's Auxiliary to the Ohio County Medical Society which was held at Oglebay Park in Wheeling on October 3.

Mrs. George M. Kellas and Mrs. James E. Spargo, both of Wheeling, presided at the tea table. Mrs. Herbert G. Dickie, Jr., of Wheeling, was chairman of hostesses. Her aides, all from Wheeling, were Mesdames Robert T. Bandi, William Barton, Norvell L. Haislip, George M. Kellas, Thomas M. Klug, L. A. Lyon and Robert M. Sonneborn.

* * * *

RALEIGH

Past presidents of the Woman's Auxiliary to the Raleigh County Medical Society were honored at the first fall meeting held at the home of Dr. and Mrs. Warren D. Elliott in Beckley on September 17.

Mrs. Richard G. Starr of Beckley, the new president, presided at the brief business meeting. She succeeds Mrs. Harry F. Cooper of Beckley.

Other new officers are Mrs. John J. Marra of Beckley, president elect; Mrs. Charles W. Merritt, Beckley, vice president; Mrs. Walter P. Griffey, Beckley, recording secretary; Mrs. Lewis N. Fox, MacArthur, corresponding secretary; Mrs. I. Braxton Anderson, Beckley, treasurer; and Mrs. John E. McKenzie, Beckley, parliamentarian.

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Book Reviews

TEXTBOOK OF OPHTHALMOLOGY — By Francis Heed Adler, M. D., Emeritus Professor of Ophthalmology, University of Pennsylvania Medical School; Consulting Surgeon, Wills Eye, Philadelphia General and Children's Hospitals of Philadelphia. Pp. 560 with numerous illustrations. W. B. Saunders Company: Philadelphia and London. 1962. Seventh Edition. Price $9.00.

Doctor Adler's latest edition of this excellent text is an up-to-date compend on diseases of the eye. The book is written primarily for the general practitioner, the pediatrician and others interested in diseases and treatment of ocular conditions.

The text is divided into chapters dealing with each section of the eye and leads off with a most interesting and well-written new chapter on symptomatology of the eye. This section, acting as a well-rounded and full differential diagnosis of symptoms, is alone worth the price of the book.

Other chapter headings include; external examination of the eyes and adnexa; examination of the eye by ophthalmoscopy; examination of the eye by other objective methods; functional examination of the eye; optical defects of the eye, the orbit, the eyelids, the lacrimal apparatus, the conjunctiva, the cornea, the sclera, ocular motility, iris, ciliary body, pupil, the choroid and vitreous body, the lens, glaucoma, the retina, the optic nerve, ocular disorders due to diseases of the central nervous system, ocular manifestations of general diseases, orientation on surgical operations on the eye and adnexa, therapeutic agents used in ophthalmology and ocular injuries.

Each section follows a definite pattern of including an excellent review of the anatomy which is brief, to the point and clearly visualized; then the very descriptive notations on the disease entity with well selected, ample and excellent illustrations and then the differential diagnosis and treatment as indicated when desirable. The knowledge of the normal is stressed; for knowing the normal, the abnormal can be readily appreciated.

The section on hypertension is especially well written and certainly would be of great value to the general practitioner, and the section on surgical procedures gives a brief and accurate review of just what transpires during some of the ocular procedures. The section on the optic nerve and ocular disorders due to diseases of the central nervous system is beautifully covered, to the point and gives the reader the information that he is looking for.

The book is extremely well written and I could only find one minor note of objection. In the all too brief discussion of contact lens the author fails to adequately note and evaluate their use in therapeutic ocular conditions, especially in minocular aphakia, keratoconus, etc. The indications in ophthalmology for the use of these appliances increases with safety each day. This is only a minor criticism of an otherwise excellent text.

Doctor Adler is to be congratulated on making this new edition even better, if that is possible, than his

previous edition. It is recommended to all general practitioners, pediatricians and those who would like accurate, brief but thorough information about ophthalmology. The text also can be recommended highly for nurses.

Ophthalmologists could gain much by reading this excellent text as it reads more like a novel than like a textbook in ophthalmology. This is a book that is to be highly recommended to those who have a need for such a volume and should be on the shelf of every general practitioner, as it is written with him specifically in mind.—A. C. Esposito, M. D.

* * * *

ELECTROCARDIOGRAPHY: FUNDAMENTALS AND CLINICAL APPLICATION—By Louis Wolff, M. D., Clinical Professor of Medicine, Harvard Medical School. Pp. 351, with illustrations. W. B. Saunders Company: Philadelphia and London. Third Edition. 1962. Price $8.50.

This book is divided into three parts. Part I, the Principals of Electrocardiography; Part II, Clinical Electrocardiography; and Part III, The Normal and Abnormal Cardiac Mechanism, Digitalis and Quinidine.

By far the most useful section of the entire book is Part II, which is devoted to clinical Electrocardiography and presented with clarity and conciseness, would be excellent as a study for anyone who is interested in this phase of medicine. Part I, The Principals of Electrocardiography, is well written but would certainly be too difficult for the beginning student in this field. Part III, The Normal and Abnormal Cardiac Mechanism, Digitalis and Quinidine, is of course the study of arrhythmias. This section is quite complex and at times very confusing.

In my opinion, one would have to be well versed in electrocardiography to get a comprehensive understanding of what the author is attempting to convey. The author states that vectorcardiography provides a superior approach to teaching electrocardiography and that all electrocardiograms were re-studied to use the vector concept of interpretation. Yet it is the reviewer's opinion that after a thorough study of this book the empirical method was used instead of the vector concept.

As a whole, however, this would be a useful reference book for anyone doing work in electrocardiography.—I. E. Buff, M. D.

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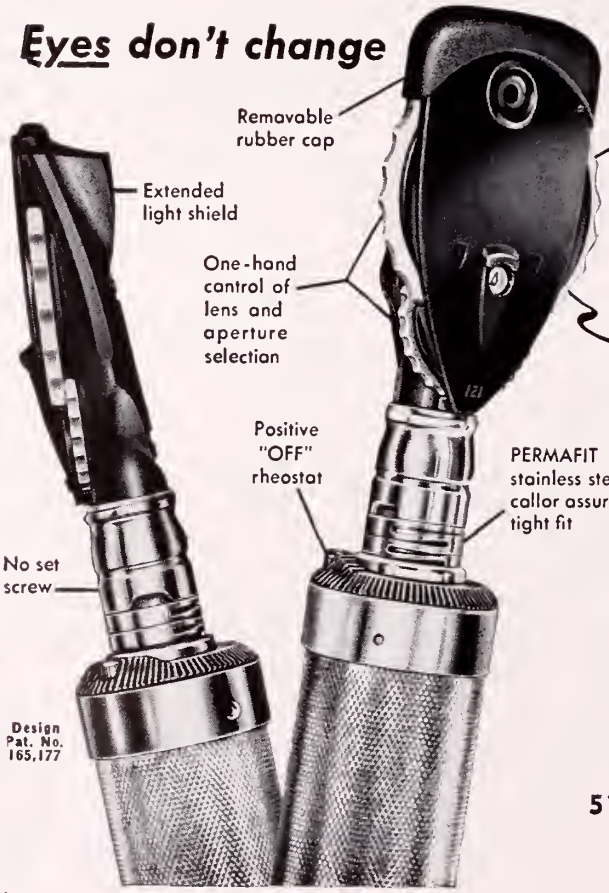

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DECEMBER
1962

Vol. 58 No. 12

The
WEST VIRGINIA
Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston 24, W. Va.

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Published monthly by the West Virginia State Medical Association under the direction of the Publication Committee. Original articles are accepted on condition that they are contributed solely to the Journal.

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

Entered as second-class matter January 1, 1926, at the post office at Charleston, West Virginia, under the act of March 3, 1879.

Subscription, $3.50 per year; 50¢ per single copy. Advertising rates furnished on request. Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 346-0551.

Member 1962

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The West Virginia Medical Journal

December, 1962 Vol. 58, No. 12

Surgical Intensive Care Unit*

Neopito L. Robles, M. D., and Walter H. Gerwig, Jr., M. D.

Until a year ago, the recovery room in our hospital, like that in many another, was depended upon as the place for immediate postoperative care for surgical patients. However, these patients remained in this area until about 4:30 P. M., which was the time that those who staffed the recovery room usually went off duty. It is likely that similar situations exist elsewhere and are familiar to other surgeons who practice in hospitals in which the recovery room functions during day hours almost exclusively.

The present discussion in no way is to be construed as criticism of the recovery room. Its purpose, rather, is to point out certain advantages of an Intensive Care Unit that functions around the clock.

Plans for our Unit were instituted on the return of one of our surgeons (Dr. George W. Easley) from a visit to the Mt. Alto Veterans Administration Hospital in Washington, D. C., which had an Intensive Care Unit in operation. Doctor Easley's enthusiasm for what he saw there convinced the other members of our hospital's surgical staff that they should work together toward the development of a similar set-up.

It was indeed fortunate that adequate and conveniently located space (used only for storage purposes) was available for conversion. Through the combined efforts of the hospital director, the chief nurse and members of the surgical service, plans were formulated, financial support obtained and conversion of the storage area to an Intensive Care Unit begun.

Indispensable After Year's Trial

The Intensive Care Unit in our hospital has now been in operation since March, 1961. It has become an indispensable part of our surgical program because of the better postoperative care it provides. As time goes on, the enthusiasm for the unit continues to mount and the unit itself is most rewarding in terms of reduced morbidity and mortality. Since it provides constant care of the surgical patient around the clock, we feel that it is far superior to the conventional recovery room.

The Authors

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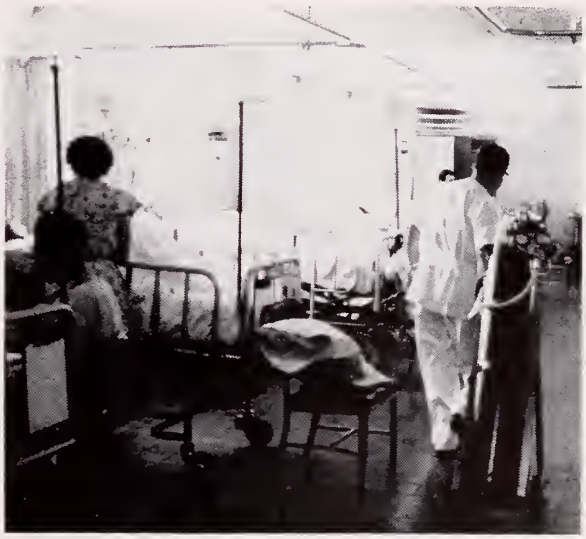

Figure 1. Surgical Intensive Care Unit at Veterans Administration Hospital in Clarksburg. Located on the surgical floor, the Unit has a capacity of 12 beds.

*Presented before the annual meeting of the West Virginia Chapter, American College of Surgeons, at The Greenbrier in White Sulphur Springs, April 12-14, 1962.

Submitted to the Publication Committee, May 31, 1962.

Appraised by Nursing Service Chief

On several occasions critical appraisal of the Unit by the chief of nursing service and her associates has been sought and obtained. The unanimous opinion has been that the quality of care afforded the postoperative patient is greatly improved by concentration of critically ill patients under the continuous management of a skilled team.

An Excellent Investment

The initial cost of establishing such a unit is somewhat formidable. The hospital administration, however, with far-sighted vision, recognized the potentials of an Intensive Care Unit and fully supported the project. Today the administration feels, also, that the Unit represents an excellent investment and that the money has been well spent.

The surgeon is able to supervise his patients more closely and to observe them more carefully when they are concentrated in the small area of the Unit than was possible formerly, when rounds were made over great geographical distances which separated certain ill patients.

Medicine's Armamentarium Constantly Available

Our surgical Intensive Care Unit is air-conditioned and the humidity can be maintained at a constant level. It is located on the surgical floor and has a capacity of 12 beds (Figure 1). Equipment such as a resuscitator, a Bennett intermittent positive pressure breathing apparatus (Figure 2), a gastric hypothermia machine, thoracic pumps, tracheostomy and cut-down trays, and various intravenous fluids, emergency medications, narcotics and miscellaneous drugs of various nature that might be needed are constantly and easily available (Figure 3).

Piped-in oxygen and wall suction are provided for each bed.

Adequately Staffed by Trained Personnel

A registered nurse and at least one nursing assistant are always present in the Unit. When there are several critically ill patients, more nurses are brought in to provide additional help. The chief nurse has been extremely gracious and cooperative in maintaining as near as possible the same nursing personnel for the Unit and it can be readily recognized that for them, such experience results in increased efficiency and ability in the management of the critically ill surgical patient

Policies and Practices

We believe that each hospital has to devise its own particular system for the development of such a unit, predicated on its own existing situations. We also believe that certain basic policies must be established to govern the admission to and duration of stay in the Intensive Care Unit. Here again, these policies must be adapted to each individual hospital.

It is our practice to admit all patients returning from the operating room, including those who have had only a local anesthetic, directly to the Intensive Care Unit, at least for a brief time. The basis for such practice is our desire to expel or prevent the thought that to be sent to the Intensive Care Unit means that the patient is extremely ill. By making it a natural course for all postoperative patients to return to their wards via the Intensive Care Unit any feeling of anxiety is alleviated. Many patients, for example, those who have had a spinal anesthetic that has completely worn off, are immediately transferred from the Unit to their various wards, while in

Figure 2

Figure 3

Figure 2. Bennett intermittent positive pressure breathing apparatus in use. Figure 3. Constantly and readily available are emergency medications, narcotics, I.V. fluids, cut-down trays and miscellaneous drugs and aids to treatment that might be needed.

the thoracic cases, patients are kept until all vital signs are stabilized, the chest tubes removed and oral feedings tolerated. Patients requiring nasogastric tubes, gastrostomy drainage or perhaps correction of electrolyte imbalance, also those in a multiplicity of similar situations, are kept, not for any definite number of hours or days, but until their physicians feel that they can well tolerate being out on the open ward. In most instances this usually is a matter of a very few days, although in some cases it can amount to a week or so. The final decision as to when the patient may go to the open ward is made by the physician.

The VA Hospital in Clarksburg has approximately 100 surgical beds. Patients are admitted to occupy a bed on one of the surgical wards. During the time that he is in the Intensive Care Unit, his bed on the open ward remains vacant. In exceptional circumstances or when the hospital is crowded, the bed may be occupied by a newly admitted patient on a temporary basis until another bed is made available. It is recognized fully that such practice in an active private hospital might very well result in many financial problems. To charge a patient both for the bed vacated and the bed occupied in the Intensive Care Unit would inflict hardship. By the same token, to have the bed of the patient unoccupied out on the ward would mean a financial burden to the hospital. It is again stressed, therefore, that the situations and conditions within the hospital itself must constitute the basis on which plans for creation of an Intensive Care Unit are founded. Our purpose at the moment is purely to emphasize the innumerable advantages that we have gained since the creation of such a unit in our institution.

The Uninformed Medical Speaker

During the past few years much has appeared in professional journals about proposed changes in the curriculum of our medical schools. In recent months some of our newspapers have evinced considerable interest in this same subject. One topic that is never mentioned when changes are discussed is the addition of a course in public speaking. There are many reasons why this should be offered as an optional, if not a regular course in medical colleges.

Physicians as a group are a rather inarticulate lot. This is especially true when they are called upon to discuss anything beyond the immediate confines of their professional work. A second closely related weakness is a failure to master the subject thoroughly before undertaking to discuss it. This is always hazardous but it may be disastrous when the subject has to do with various plans to furnish medical care for the aged. This topic has more than the usual quota of pitfalls.

Our adversaries are generally well informed and they relish nothing better than the opportunity to highlight some inaccuracy or inconsistency in a presentation by a physician. Many of our opponents are paid propagandists whose livelihood depends upon their ability to engage in rough and tumble debate. The cause of medicine is not advanced by the unwary physician who enters the arena with such an adversary and attempts to give battle without a thorough knowledge of his subject. This is true whether he speaks at a service club in his home town or appears before a congressional committee meeting in Washington.

We cannot all have the oratorical ability of Dr. Edward Annis but at least we can fortify ourselves with the facts before we attempt to speak.—Harry J. Warthen, M. D., in Virginia Medical Monthly.

Hip Dysplasia*

Edward M. DeYoung, M. D.

Hip dysplasia is the second most common developmental abnormality in the infant. Its frequency of occurrence is exceeded only by that of clubfoot.

The term, "dysplasia," is a general one, indicating the presence of malformation. Severity of the entity ranges from hypogenesis of insignificant degree to dislocation of the femoral head. Unlike clubfoot, hip dysplasia is not present at birth. It results, not from defective genes nor from intrauterine misfortunes, but from handling the infant prior to the crawling stage in a manner adverse to normal development.

At birth, the hip joint is entirely cartilaginous. Whether or not it will be prepared for weight bearing at the end of nine months depends entirely upon the stress to which it is subjected in the interval. Normal development will take place only if the femoral head is maintained in firm pressure against the growing acetabulum. Conversion of cartilage to bone in orderly fashion is dependent upon the external stress to which the area is subjected. Osteoblasts constantly build and rebuild bone in response to the muscular action imposed, e. g., witness the facial deformities resulting from congenital torticollis. The femur, being a long bone, can become an effective lever in transmitting stress to the hip joint. If the growing infant's hips are subjected to force which tends to withdraw the femoral head from its socket, the stage is set for dysplasia.

The femoral head is best presented to the acetabulum when the legs are abducted, the position they naturally assume when the infant is unencumbered by clothes and lying on his back. The weight of the legs slowly overcomes muscle pull and the knees soon almost touch the surface on which the infant is lying. In this position, the femoral head is jammed into the hip socket and normal development progresses. A bulky diaper enhances the abduction unless the knees are held together by restrictive clothing, in which case the diaper becomes the fulcrum and the femur the lever which withdraws the femoral head from its socket.

*Presented before a meeting of the West Virginia Radiological Society in Clarksburg on May 5, 1962.

Submitted to the Publication Committee, May 25, 1962.

The Author

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Frequent in Ancient Rome

Since ancient Roman times, the latter situation has produced thousands of cases of dysplasia annually in Northern Italy. Because of the frequency of hip dislocation in that region, the abnormality became a matter of great interest to Italian physicians. The largest series of cases ever assembled came from there. It was assumed that the condition was due to hereditary forces until Hart[6] pointed out that the incidence of dysplasia in immigrant children in the United States who were from that area was not higher than that among other Americans. In Northern Italy and Southern France, from ancient times to the present, the infant is prepared for the day by bulky diapering and swathing of the legs and trunk, simulating the appearance of a miniature mummy. Hart's book on dysplasia contains photographs of terra cotta tiles from Roman excavations depicting children wrapped in the manner described. The child is not arrayed in this fashion for frequent diaper changing and it can be assumed that the soft structures about the hips are subjected to adverse traction for long periods each day. In families emigrating to the United States the traditional handling is abandoned and the high incidence of the disease disappears.

Unknown in the Orient

While in the case of Italy's child we have force applied which works in a manner adverse to normal hip development, the situation with regard to the young Oriental is the opposite. Consider the classic image of the Oriental mother with her child. Immediately there comes to mind an infant being carried astride its mother's hip, the optimal position for normal hip development. The femurs are levered apart, forcing the heads into the acetabula. It is not surprising that hip dysplasia is unknown in the Orient.

Diagnostic Signs

If, prior to weight bearing, the hip joint is subjected to force which stretches the capsule and delays ossification of the articular cartilages, subluxation or dislocation will ensue when weight bearing occurs. Crawling at approximately seven months produces the first weight bearing. This is the time when most hip disabilities come to light. Signs which lead to the diagnosis are clearly visible to the mother whenever the infant's diaper is changed. The normal infant lying on his back flexes his legs and with the relaxation of the procedure, the thighs are slowly abducted until the knees are almost touching the table. The infant with hip dysplasia exhibits noticeable adduction of the involved thigh and the mother has difficulty maneuvering the leg while pinning the diaper. The obvious difference in the movement of the leg prompts her inspection at each diaper change and she soon discovers that there is asymmetry of the folds of the skin in the region of the groin. Since the infant almost always is a female, the characteristic covering of one-half of the labium on the involved side by a deep inguinal skin fold is apparent.

Treatment

Treatment of hip dysplasia is abduction of the thigh or thighs for several months by mechanical means. A Frijka pillow or any one of the many abduction splints devised may be used. The treatment does not cause discomfort and after a few weeks the infant can be cared for by the family with little additional inconvenience. If the warning signs on physical examination and on the roentgenograms are not heeded, the child will suffer hip disability of varying degree for the rest of his life.

Complete Dislocation the Lesser Evil

The most dramatic catastrophe that can happen is dislocation of the femoral head completely out of the acetabulum. Strangely enough, the adolescent or adult thus afflicted is able to ambulate for more years and with less discomfort than the individual in whose case subluxation occurred. It is not generally appreciated that subluxation, or incomplete dislocation of the hip, is productive of more severe osteoarthritic changes than complete dislocation. Proof of this situation has been called to our attention on several occasions by Hart, Colonna[3] and others, who have followed patients in whose cases no more than subluxation took place in childhood, but for whom proper therapy was refused by the parents. These individuals are troubled with painful hips when in their early thirties. Unrecognized subluxation accounts for the bulk of the arthritides requiring fusion or cup arthroplasty before the age of forty.

Since the radiologist seldom is called upon to examine the infant initially, there is no particular reason to describe in detail the various signs and maneuvers which make the diagnosis obvious to the pediatrician and the orthopedist.

Examination will result in the following observations: (1) Abduction is diminished in the involved thigh; (2) The infant does not move one extremity as freely as the other; (3) There is a difference in the rotational altitude of the extremities; (4) There is asymmetry of the labia. Actually, the labium on the involved side is partially concealed by the inguinal fold. The baby powder remains in one unusually deep skin crease in the side affected; (5) The knee, popliteal and ankle creases are at different levels on their respective extremities. One extremity seems shorter than the other; (6) A clicking sound or a palpable and visible jerk occurs at the hip level with movement of the thigh; (7) One side of the pelvis or hip may be prominent.

Identification Aids

Before discussing the roentgenologic features of the hip dysplasia some general statistics are in order. The following data applies to those cases that are strictly postnatal in origin, which group comprises 95 per cent of all cases of infantile hip dysplasia. The remaining 5 per cent can be considered as congenital since in these the abnormality is associated with multiple defects at birth.

The following information will aid in identifying postnatal dysplasia:

1. In 80 per cent of cases, the patient is female.

2. In 60 per cent of cases, the left hip is involved.

3. In 80 per cent of cases, the dislocation is posterior.

4. There is an increase in the anterior angulation of the femoral neck with respect to the shaft, as compared with the average.

5. The entire involved half of the pelvis may demonstrate delayed maturation as compared with the normal half.

6. Familial association might well be related to the traditional handling of infants as indicated in the cases occurring in Northern Italy.

7. Proper therapy before dislocation takes place results in completely normal development, with no late disability of the hip.

Roentgenologic Features

With the therapy of dysplasia so simple before weight bearing, it behooves the radiologist to lean in the direction of over-diagnosis rather than to assign a normal label to cases in which the findings might be questionable. Caffey,[1] in his text, "Pediatric X-Ray Diagnosis," performed a disservice with regard to the proper handling of these infants when he emphasized the occasional spontaneous disappearance of roentgenologic signs of dysplasia without known formal therapy. Since forced abduction of the thigh is all that is necessary, it is possible that the purchase of a hobby horse or the appearance of a new baby sitter would prove to be all that was needed to produce the unsuspected manipulation that places the femoral head in proper relation to the undeveloped acetabulum.

Roentgenologic signs of the disease are clear-cut:[2]

1. An increase in the acetabular angle.

2. Delayed ossification of the involved femoral head epiphysis.

3. Lateral displacement of the femoral head.

The foregoing triad first was published by Putti,[8] in 1929. It is in itself sufficient for diagnosis of dysplasia in the non-weight bearing infant. The importance of the x-ray examination in diagnosis and treatment cannot be overemphasized.

The Acetabular Angle

Measurement of the acetabular angle first was described in the published report of Hilgenreiner, in 1937. The construction of these angles is illustrated in Figure 1.

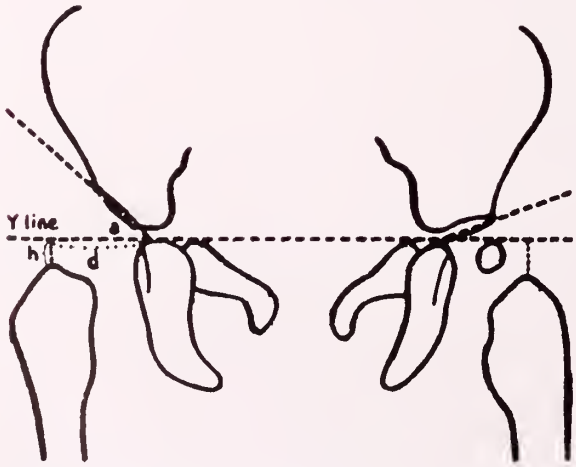

Figure 1. Hilgenreiner's measurements. Note the Y line, acetabular index (a), high position of the diaphysis as measured from the most proximal shadow of the diaphysis to the Y or tri-radiate line (h), increased distance from the most proximal shadow of the diaphysis to the acetabular floor (d). Also observe the delayed closure at the ischiopubic junction.

Hilgenreiner stated originally that any angle greater than 20 degrees must be thought of as an index of predislocation. With the passing of time, it has become apparent that angles to 26 degrees, when not associated with other roentgenologic signs, may be considered normal.

Angles of increased degree are due to delayed osteoblastic activity, the result of insufficient stress on the development cartilages. Growth of the cartilages themselves is not arrested. The increasing mass of cartilage, when subjected to weight bearing, is deformed in the same fashion as the developing cartilage mass in rickets.

Femoral Head Ossification Center

The various kinds of force which allowed delayed ossification of the cartilage forming the roof of the acetabulum are the same that bring about reduced ossification of the femoral head. When dealing with unilateral disease, the inequity of size of the femoral heads is obvious.

Average sizes of ossification centers are shown below in tabular form:[4]

1 - 3	months	invisible			
4	months	2	x	2	mm.
6	months	5	x	3	mm.
9	months	7	x	5	mm.
1	year	10	x	7	mm.
1½	years	12	x	9	mm.
2	years	17	x	10	mm.
3	years	20	x	11	mm.
4	years	25	x	12	mm.

Outward or Upward Displacement of the Femoral Head

This last index in Putti's triad is helpful but not absolutely necessary to warrant institution of corrective treatment. If a line is constructed at right angles through the base line of Hilgenreiner, contacting the outermost aspect of the ossified roof of the acetabulum, the head of the femur should lie beneath or medial to such line. In subluxation, the femoral head will lie lateral to the line.

Shenton's Line

Another time-honored index of abnormal placement of the hip is Shenton's line.[5] This curving line is seen on the roentgenogram of the normal hip. It is formed by the top of the obturator foramen and laterally by the curve of the femoral neck and the lesser trochanter. In normal relation, these two structures fortuitously describe a perfect semicircle. With outward or upward displacement of the femoral head and neck, the symmetry of this landmark is disturbed. The observation is much less reliable in diagnosis of dysplasia in the infant than it is in that of the older patient, largely because it depends on symmetrical placement of the legs with respect to rotation. Accurate positioning of the legs receives the attention of the technician during film-

ing of the adult, but in the case of the infant the practice is less commonly observed.

In cases of frank dislocation, the abnormal placement of the femoral head is the most dramatic observation on the film. In these cases, the diagnosis can be made from the physical signs, the gait and the general appearance of the child. Films nonetheless are necessary for confirmation and for purposes of record with regard to efficacy of treatment.

Treatment: Extent Proportionate to Delay

Detailed discussion of treatment is not within the scope of this paper.

When actual dislocation has not taken place, the wearing of an abduction splint is universally successful in producing a normal hip by the end of six to nine months. If treatment is delayed until dislocation has occurred, the complexity of the treatment and the frequency of aseptic necrosis are directly related to the duration of the dislocation.

Under one year of age, manipulation and casting or splinting usually are sufficient to effect a cure. In this group, aseptic necrosis of the head follows in 12 per cent of cases. Under two years of age, traction, manipulation and casting are required and aseptic necrosis appears in 59 per cent of cases. In those over 2 years of age, traction and open reduction become necessary, with necrosis appearing in 62 per cent of cases. In patients over four years of age, reconstructive surgery is universally required. These facts are related to emphasize the importance of early diagnosis and adequate treatment.[7]

Summary

Hip dysplasia before weight bearing has occurred is manifestd by distinct physical signs.

Roentgenologic examination is indispensable in diagnosis and treatment of the disease. Roentgen signs likewise are dependable and clear-cut.

Therapy is simple and effective.

Results of late treatment are so poor that in all suspected infantile cases, treatment should be instituted as soon as the diagnosis is confirmed.

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Aftermath of Saskatchewan

As the smoke of battle settles after the struggle between the government of Saskatchewan and its physicians let us look critically at some of the basic issues involved. Careful appraisal indicates that even outside "The Curtain" a government can be capable of ruthlessly confiscating the services of a special group of its citizens without any justification imposed by a state of war or other disaster.

Confiscation is an accurate word to use here because the Saskatchewan law recently passed gave the government complete economic regulation of its physician citizens including payment for services, and the conditions under which these services were to be rendered. There was no provision for negotiation. Except for the fact that they were privileged to leave the country, this law imposed involuntary servitude upon the members of the medical profession.

The second important fact to realize is that by cohesive group action the physicians of Saskatchewan successfully resisted this tyranny. Hopefully, we suggest that this social tragedy enacted by our northern neighbors will stimulate sober constructive thinking in this country to the end that reenactment here of the Saskatchewan agony will be avoided. —Westchester Medical Bulletin.

The Routine Roentgen Examination of the Abdomen*

C. H. Lee, M. D.

No one today will question the value of routine chest x-ray, but few will subscribe to the wisdom of routine roentgen examination of the abdomen. It is not generally realized that a routine x-ray film of the abdomen is just as important, if not more so, to the surgeon as is a chest x-ray film to the internist or general practitioner. Numerous surgical problems can be solved easily by a procedure as simple as routine roentgen examination of the abdomen. By the same simple procedure numerous unnecessary surgical operations can be avoided.

The value of a routine x-ray film of the abdomen has long been recognized by Dr. William R. Laird who, in 1955, suggested that routine x-ray of the abdomen at no cost to the patient, be initiated on an experimental basis. The results to date have been so gratifying as to convince us that the procedure can and should be recommended as a part of our routine examination of patients.

In cases in which the x-ray film of the abdomen is clearly indicated, the percentage yield of positive findings naturally is high. It is unnecessary to dwell on the value of a routine abdomen film in cases with a clinical diagnosis of intestinal obstruction, urinary tract disease, perforation of abdominal organ, cholecystic disease, localized and generalized peritonitis, pancreatitis, subphrenic abscess and the like.

*Presented before a staff conference at The Laird Memorial Hospital, Montgomery, W. Va.

Submitted to the Publication Committee, May 17, 1962.

The Author

- **C. H. Lee, M. D., Radiologist, The Laird Memorial Hospital, Montgomery, W. Va.**

In a case of acute pneumocholecystitis the film of the abdomen presented the first clue. (Figure 1). In a case of intussusception of the colon the condition is clearly shown (Figure 2).

In cases in which a routine film of the abdomen was not clearly indicated the procedure has yielded rather gratifying results, e. g., a case of calcified mesenteric cyst was reported in *The West Virginia Medical Journal* (November 1961).

A calcified cyst of the liver was accidentally discovered. An oral cholecystogram revealed the gallbladder to be situated below the cyst (Figure 3).

A calcified urinary bladder on a routine abdominal film has led finally to the diagnosis of carcinoma of the urinary bladder (Figure 4).

In a case of active pulmonary tuberculosis a routine abdominal film revealed excessive calcification of the vas deferens (Figure 5) which apparently also is of a tuberculous nature. An upright film of the abdomen, after giving the patient some soft drinks, is sometimes of great help in the visualization of abdominal masses or

Figure 1
Pneumocholecystitis

Figure 2
Intussusception of Colon

Figure 3
Calcified Cyst of Liver

enlargement of the spleen, as is demonstrated in a case of Hodgkin's disease (Figure 6).

In still another group wherein routine x-ray examination of the abdomen is not indicated, or even perhaps contraindicated, rather surprising results have been obtained. But for these films, some serious diagnostic errors would have been made. Some illustrative case reports follow:

Case 1—A 72-year-old white male was admitted with a history and physical findings that could be described as strongly suggestive of coronary occlusion. The patient was experiencing intense precordial pain with radiation to the left side of the neck and down the left arm. He was cold, dyspneic and apparently in shock. An immediate electrocardiogram failed to reveal any abnormality, but the possibility of a coronary occlusion was not excluded.

A routine film of the abdomen, which would appear contraindicated, was made (Figure 7). This was interpreted as showing mid-ileal obstruction. The patient, however, did not have symptoms or signs of intestinal obstruction. There was no nausea, vomiting, rigidity, distention nor abdominal tenderness. In fact, after clinically examining the patient the author was also convinced that he did not have intestinal obstruction.

After twenty-six hours signs and symptoms obviously of intestinal obstruction developed and, on surgical intervention, the diagnosis of mid-ileal obstruction was confirmed. Repeated electrocardiograms during hospitalization were consistently normal. The postoperative course was uneventful. Subsequent follow-up electrocardiograms have been normal to date, a period of nearly five years.

Case 2—A 2-day-old white male was seen in the Tumor Clinic because of a 6.0 cm. hard mass in the sacrococcygeal region. The mass was of bony consistency. The patient also had multiple congenital deformities of the genitalia, a lumbar meningocele, and bilateral talipes calcaneovarus. It was the unanimous opinion of the members present at the Tumor Conference that the hard sacrococcygeal mass represented a teratoma. A routine film of the abdomen, however, revealed the mass to be an incarcerated hernia (Figure 8). At surgical exploration an incarcerated direct inguinal hernia was found on the left. The gas in the intestinal loop apparently was under such high pressure as to give the mass the feel of bone on physical examination.

Case 3—A 6-day-old white male was seen in the Clinic because of vomiting and oliguria since uncomplicated delivery. The patient was unable to retain any food by mouth and appeared hungry all the time. Two small meconium stools had been passed since birth.

On physical examination the child appeared well nourished and hydrated, weighing 7 lb., 5 oz. Such a case could easily have been passed for some feeding problem and no serious disease would have been thought of. A routine film of

Figure 4
Calcified Carcinoma of Urinary Bladder

Figure 5
Tuberculosis of Vas Deferens

Figure 6
Hodgkin's Disease

Figure 7
Mid-ileal Obstruction

the abdomen revealed a markedly distended stomach containing a large amount of gas but no gas was seen in the remainder of the gastrointestinal tract (Figure 9).

The absence of the gas in the intestinal tract in a 6-day-old infant is clearly indicative of intestinal obstruction unless the patient has had severe diarrhea. To differentiate congenital hypertrophic pyloric stenosis from duodenal atresia the patient was placed in a recumbent right anterior oblique position for a film of the abdomen. This revealed marked distention of the duodenum down to the junction of its second and third portions (Figure 10). At surgery the diagnosis of duodenal atresia was confirmed. Patient had an uneventful postoperative course and gained one pound of weight during the following week.

Summary

The value of a routine film of the abdomen has been discussed. It is felt that such a film can and should be emphasized as a part of routine physical examination.

Figure 8
Incarcerated Hernia

Figure 9
Duodenal Atresia

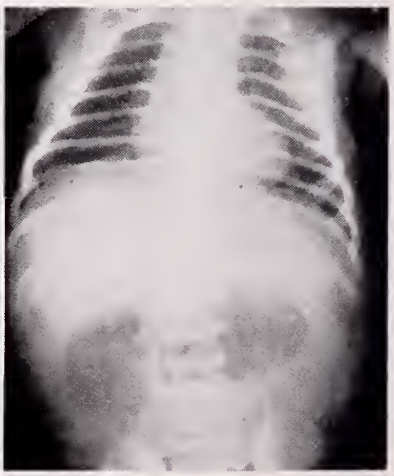


Figure 10
Duodenal Atresia

Special Article

Selected Topics on Forensic Medicine

Charles E. Goshen, M. D.

THE doctor-patient relationship has the force, in law, of a legal contract, in which both parties assume certain responsibilities. Like other contracts, also, both parties have the right to accept or reject it in advance. For example, the physician is not required to accept everybody as a patient, but has the right to refuse his professional services. However, once he has accepted a person as a patient, he becomes responsible for his side of the contract, while the patient, in accepting the physician as his physician, assumes certain responsibilities.

In general, the physician's responsibilities are those of rendering a level of professional care which is in keeping with the current state of the art. The patient's responsibilities include the necessity of his cooperating with the treatment offered, and making suitable compensation for the service. Either patient or doctor may terminate his part of the contract by giving due notice to the other party.

Failure of the physician to exercise the ordinary degree of skill, care and judgment which prevails among the members of his profession practicing in the same or similar area may render him liable for malpractice. However, physicians are often sued for malpractice on the grounds that a patient has sustained some damage, suffering or injury regardless of whether the physician has failed in his responsibility or not. Attorneys for patients making such claims sometimes attempt to introduce the principle known as "res ipsa loquitur" in which the existence of any kind of damage to the patient which resulted from medical care is assumed to mean the physician was negligent. When a court accepts this principle, it may leave very little grounds for defense.

Although the law does not require that treatment be successful in order to absolve the physician of the charge of negligence, trouble might arise if the physician appears to guarantee a successful outcome which does not, then, materialize. The requirement that a physician's level of professional care be in keeping with that of other physicians in his or similar area has the effect of imposing the necessity of keeping abreast of medical progress. On the other hand, the introduction of new treatment measures always poses the danger of malpractice suits if damage results since the test of a physician's responsibility is whether or not his care conforms to established methods of treatment. This particular danger may seem to sabotage progress in medicine, but also serves to curb the use of reckless experimentation. It is important to note that a patient's failure to pay for medical service does not absolve a physician from the charge of negligence on his part.

In order to protect himself against the financial risk of large malpractice claims, it is almost obligatory that each physician obtain malpractice insurance. Companies which sell such insurance not only contract to pay these claims when courts rule in favor of the plaintiff, but also provide legal representation in the defense. When a physician works in a hospital or with a medical group, he might be covered by a blanket policy which affects equally all the physicians and other employees in the organization. Such policies generally do not cover any work done outside the auspices of the organization. For the private practicing physician or for the physician who plans to do extra-mural work, an individual insurance policy will be needed. In the military service, malpractice is construed to mean the "wilful" intent to do harm to a patient, and since this almost never happens, and could be proven only with great difficulty, malpractice insurance is not as necessary for the military physician.

The Author

- **Charles E. Goshen, M. D., Associate Professor of Psychiatry, West Virginia University School of Medicine, Morgantown, W. Va.**

Submitted to the Publication Committee, May 31, 1962.

Examples of Possible Grounds on Which Malpractice Suits Against a Physician Might be Based

1. Criminal negligence; in which a patient is injured through the commission of a criminal act (illegal abortion, for example) or through wilful intent to harm.

2. Civil negligence; in which an injury was sustained as a result of a physician's failure to exercise ordinary discretion and judgment.

3. Negligence of a third party; in which an employee of a physician or hospital is negligent in such a way as to inflict harm. The physician in charge might be held responsible if the negligence occurred in carrying out his orders.

4. Treatment without consent can be grounds for a suit without proving negligence. The possibility of this is most likely to happen when an unconscious patient is treated, or if a child is treated without the consent of parents. A few states have recently passed "Good Samaritan" laws to protect physicians against such suits when they happen upon an accidental injury and offer treatment to an unconscious patient. In obtaining consent for operations it is almost obligatory that the consent be in writing and that every possible contingency be stated. Rules applying to children also apply to mentally incompetent people, in that the consent of guardians must be obtained.

Certain Legal Duties Required of Physicians

1. Physicians are generally required to report all suspicious or accidental deaths to the local medical examiner or coroner. In some cities and states, all injuries resulting from acts of violence must be reported to the police.

2. Physicians are often required to report any knowledge they have of the illegal practice of medicine by other persons.

3. Physicians are required to report all births, deaths and certain communicable diseases to public health authorities.

4. A particularly significant type of report which physicians are required to make, either by statute or by their implied duties as citizens, concern illegal abortions. The complications and deaths due to illegal abortions are most likely to come to the attention of respectable physicians, and when this arises, the information should be reported to the district attorney, although it is usually necessary to get the patient's consent, or to withhold the identity of the patient.

Privileged Communication

Under common law, communications made to physicians by his patient are not privileged, but most* states have statutes which specifically declare the right of privileged communication to the patient. This means, in essence, that a physician cannot legally make use of any information he obtains from the patient without the latter's consent. For example, when a physician writes a medical article or gives a talk on a certain case, if the particular patient can be identified from this material, permission must be obtained. This would almost always apply, for instance, if a photograph of the patient is used. The intent of this law is to encourage the patient to feel free to disclose information which will help in his recovery.

In states where privileged communication statutes prevail, and even when a physician is subpoenaed by a court to present testimony about his treatment of a patient, the latter can object to this being presented in court. If the patient does not object, the physician may disclose the information requested. The procedure by which the patient withdraws his right to object is called "waiving the privilege."

Even when the patient asserts his privilege, the physician can still testify to certain facts, such as the number of visits he made, whether or not the patient was hospitalized, and what operations or diagnostic aids were performed. He may not, however, testify as to the nature of the illness. Any doubts on such matters should be clarified by conference with the judge.

Suits can be brought against physicians for violation of a patient's right to privileged communication. When this is done, it becomes, essentially, a libel suit.

A hypothetical question is often posed concerning privileged communication which actually arises as a real conflict only rarely. This question is one which foresees a possible conflict between a physician's responsibility to his patient and his responsibility to his community. For example, a physician might acquire information from a patient which could affect the public safety, or the nation's security, and to disclose it would risk a violation of the privileged communication statutes. When such a conflict does exist, the physician must make his decision by weighing the two risks involved.

In actual practice, one of the greatest hazards in this privileged communication area is faced when employees of the physician or other unauthorized persons acquire information which might be embarrassing to a patient. Nurses and secretaries are generally not as deeply impressed as physicians are with the need for secrecy and the greatest of care must be exercised in sharing information about patients with such personnel.

*31 states and the District of Columbia.

It is important to note that the right of privileged communication is contained in the Hippocratic oath and is, therefore, embodied in medical ethics, even though it is not specifically provided for in the laws of certain states.

Workmens Compensation

All states now have workmens compensation laws which hold employers liable for injuries employees sustain at work. This means that nearly all employers are required to carry insurance which pays for claims made by injured workmen. A very large proportion of all physicians become involved in these issues because work injuries are likely to represent a substantial share of any medical practice. The disabilities resulting from compensable injuries are frequently used as grounds for making claims against insurance companies. The physician who treated the injuries thereby become a candidate for courtroom appearances.

Workmens compensation hearings are generally conducted by referees of the Workmens Compensation Commission. Although they might be held in courts and in accordance with established courtroom procedures, they are somewhat different from standard civil and criminal proceedings. They generally do not use a jury, and the referee or commission which hears the case is likely to be fairly well informed on the subject of medical testimony, medical disability, etc. They are also more likely to be sympathetic with a physician. In most states, the provisions and administration of the workmens compensation law are determined in collaboration with designated committees of the state and/or county medical societies.

Specific physicians are appointed by either the county medical societies or a state commission to serve as compensation physicians. Nearly all licensed physicians can, and usually do, qualify either as general physicians or as specialists. A prescribed schedule of payments is established for each type of examination and treatment, and a considerable amount of paper work is required to participate in this kind of medical practice. Because there is always a high probability that any records submitted by a physician might be used in litigation, it is very important to exercise care in making these records as complete and accurate as possible. It is particularly important to use standard medical nomenclature with appropriate code numbers.

It is not unusual for an insurance company to ask another physician to examine an injured employee who is making a disability claim. If this physician offers an opinion different from that of the claimant, the physician might have to appear at a hearing on the side of the insurance company, and is likely to be in the position of offering testimony which opposes that of another physician. These situations are not only embarrassing to the physicians concerned but also confusing to the referee hearing the case. When in a situation like this, it often pays to present testimony which first outlines the areas of agreement between the opposing views and then offers a plausible explanation for those details about which there is disagreement, providing, if possible, a way of explaining the other physician's different opinion in a fashion which helps him save face. This might be done by emphasizing the additional information you have, implying that if the other physician had this additional information he would arrive at the same opinion.

Expert Testimony

Physicians are frequently called upon to serve in court proceedings as expert witnesses, in which case it is their professional opinions which are offered in evidence rather than their knowledge of specific events in question. When a physician is put on the witness stand as an expert, he is first required to qualify himself. To do this, he states what his professional qualifications are, including data concerning his training, his experience, his publications, his titles and professional society affiliations. The opposing attorney and judge are then asked to accept this evidence as proof of his expertness. Any or all of the evidence might be challenged by cross-examination, so it is important that the statements made be strictly accurate. Once his expertness is accepted by the court, he is then asked to state his professional opinion about one or more points in the case. These questions asked generally concern the probable cause of some condition in a patient, or the degree of disability or the state of sanity.

A physician may be qualified as an expert in medicine in general or in a particular medical specialty. Generally, the specialist's opinions are given more weight than the non-specialists, although the specialist's opinion must be confined to his particular area of specialization.

The medical expert might be the plaintiff's regular physician, or he might be an outside physician who has examined the patient at the request of the defendant (such as an insurance company) or he might be an expert who has never seen the patient. In the latter case, the expert is usually asked to give his opinion on a "hypothetical question." This question is put by an attorney in such a way as to attempt to simulate some actual situation to which the physician is asked to reply as if it were one he had actually been confronted with. If the attorney

expects an unfavorable opinion from the medical expert he may try to slant or distort the hypothetical question in such a way as to elicit a favorable opinion. The physician's entire testimony might then hinge on one word, "yes" or "no." Because of the importance of this simple answer, the utmost care must be exercised before answering it. Consultation with either the judge or with an attorney might be requested before giving an answer.

Most criticisms of medical testimony are to the effect that they employ technical terminology which the layman does not understand. Translating a medical opinion into lay English may result in loss of accuracy, on the other hand. A useful compromise is to first state the opinion in medical language, indicating that this represents the opinion offered, but then this might be further explained in non-technical language as simply as possible. A convenient guide to measuring success in such efforts is to determine whether or not the judge understands the opinion, relying on him, then, to charge the jury accordingly. The opposing attorney might make very little effort to understand if he feels that the opinion would weaken his case, and may, in fact, try to exaggerate the difficulties of explanation.

The most stressful part of giving medical testimony is that of facing a cross-examination by an opposing attorney. His case may depend entirely upon discrediting medical testimony, so he is likely to go to great lengths to do so. A responsible attorney usually realizes the fact that people generally trust and respect physicians, and are not usually sympathetic to someone who tries to belittle or embarrass physicians. The less responsible attorney whose case depends entirely upon discrediting a physician's testimony may stoop to all sorts of devices. A simple and practical plan to follow in such instances is as follows: Decide clearly and precisely in advance what your opinion is, and then simply repeat it as an answer to all questions. Such a plan may make for a somewhat unspectacular performance on the witness stand, but the alternative of attempting to outwit an attorney at his own game is likely to prove embarrassing and the temptation to do so is best ignored.

Negligence suits involving large claims are likely to be dragged out in courts over a period of years with appeals and re-trials. These situations might require a medical expert to testify several times on the same points. Any change in his testimony is likely to be used by the opposing attorney to support the case of the opposition, and it is generally desirable to review previous testimony very carefully in order to insure that it is repeated accurately. Court records are available for this purpose.

Criminal Responsibility

English common law has long recognized the fact that crimes committed by certain persons, particularly children, must be treated somewhat more leniently than when committed by other kinds of people. Since people who are mentally incompetent have long been regarded by the law as similar to children, the principle of absolving a person of guilt by reason of mental incompetence has deep roots in legal tradition. This principle was formalized in the so-called "McNaghten Rule" in England in 1843, and has been adopted in the statutory laws of the various states of the U.S. The important part of this rule is the test which it sets up for determining competency. This test is stated as follows: "A defendant may be held as not responsible for a crime if it can be shown that he was laboring under a defect of reason from disease of the mind as not to know the nature and quality of the act; or, if he did know it, that he did not know he was doing what was wrong."

The McNaghten Rule has often been criticized as an obsolete test which does not take into account the progress made by psychiatry, and various attempts have been made to modify it. A notable example is the so-called "irresistible impulse" principle which was accepted in the courts of Washington, D. C., for a number of years. It was meant to supplement rather than supplant the McNaghten Rule, and holds that a person could be held unaccountable for a crime if it had been carried out while the person was under the control of an inner drive which was too powerful for him to resist.

Another modification is now in force, by law, in the State of New Hampshire and the District of Columbia, and is known as the "Durham Decision." This decision was rendered by Judge Bazelon of the Court of Appeals for the District of Columbia as an attempt to establish modernized criteria for legal competency. According to this decision, a person may be held innocent of a crime by reason of insanity if it can be shown that he suffered from a mental condition at the time of the crime and that the crime was a "product" of this condition. In practice, this new test of criminal responsibility is an advance over the previous one by virtue of the fact that medical testimony may include a complete history and explanation of the defendant's mental status. According to the McNaghten Rule, medical testimony consists of a simple "yes" or "no" answer to the question contained in the rule. A committee of the American Bar Association is in the process

of studying the desirability of extending the Durham Decision to other states, and if they approve of it, many of the states are likely to endorse it.

Many communities have no psychiatric manpower, and local non-psychiatric physicians are often called upon to determine the criminal responsibility of persons charged with crimes. Frequently, courts will appoint a commission of three physicians to examine and report on such cases. As a result of this practice, almost any physician might be placed in the position of having to testify in such matters. When called upon to do so, it must be borne in mind that the issue at stake will be that of determining whether or not the defendant meets the particular test of legal sanity which is used in the jurisdiction in question. This determination might be quite different from that ordinarily used in making diagnoses or disposition of psychiatric problems.

Commitment to Mental Institutions

Nearly every physician is likely to be called upon to participate in the commitment of patients to mental institutions, whether he wants to or not. There is some value, therefore, in appraising one's self in advance of what the issues and procedures are, if for no other reason than to recommend suitable channels to go through.

It is useful, in the first place, to develop some simple criteria by which you would endorse or recommend a commitment. The mere fact that somebody in the family or community is seeking to commit a person is not reason enough to do so. Neither is it reason enough when it is found that a serious psychiatric problem exists. Public mental institutions generally offer very little, if anything, in the way of a treatment or rehabilitation program, but provide only custodial care. When a serious problem is found to exist, every possible treatment resource should be tried first, and commitment should be used only as a last resort. In the latter case, then, commitment would be advisable only if there seems to be a high degree of probability of the patient doing harm to himself or others. It is vital in any physician's practice to keep up-to-date information on the treatment facilities available, the procedures for making a referral, and knowledge about costs, etc. Very often, a private hospital a hundred miles away, or a private psychiatrist fifty miles away is a better alternative than a public institution.

Commitment to mental institutions is a highly legalized process because of the fact that committed people are deprived of their civil liberties, making it necessary to establish legal safeguards which protect the person's rights. Failure to exercise discretion in the use of commitment powers exposes physicians to the threat of lawsuits, particularly because psychotic patients and their families are likely to be litigious.

Most states provide three different ways by which commitments can be carried out. One type is a court commitment in which a complaint is filed in court by some third party and the court orders the patient to a state institution. There may or may not be a trial, and, in some instances, the court will ask that the patient be examined by two or three physicians. It is not uncommon for patients committed in this way to be apprehended by the police and kept in jail until these procedures are completed. This is almost always an inhumane and needlessly burdensome way of getting someone into a hospital, and in those communities where this practice prevails, it should be the responsibility of medical societies to show leadership in making changes in it.

Another type of commitment is often called a "two-physician certificate." Nearly all states provide for this method, although it is not commonly employed in some communities because of the reluctance of physicians to get involved. This type requires that two licensed physicians examine the patient, fill out appropriate forms concerning their findings, then send the patient to the mental hospital accompanied by these forms. In some states, one copy of these certificates must be sent to the judge of the county court for endorsement. Nearly all commitments could be handled with this procedure, and, if used, would eliminate the role which police, jails and courts now play in commitments.

A third type of commitment possible is known as a "voluntary" one. This, too, requires the filling out of certain prescribed forms, but only by one physician. It is applicable in those instances where the patient is relatively cooperative about going into a hospital. Patients so committed are usually given the privilege of leaving the hospital when they wish, after giving the superintendent three days' notice.

. . . we judge of man's wisdom by his hope.

Ralph Waldo Emerson.

A Special Report by the Kanawha Medical Society

In the following pages is a full text of a report submitted to Mr. W. Bernard Smith, Commissioner of the Department of Welfare for the State of West Virginia. This report was submitted by a committee of fourteen physicians from the Kanawha Medical Society. We were charged with the examination of men from Kanawha County who received Aid for Dependent Children from the Department of Welfare on the basis of disability. The 329 men we examined,* in addition to being disabled, were responsible for children and other dependents needing financial support.

There were two general areas for this examination: (1) what causes for disability existed in this group of men, and (2) how many so labeled were in our opinion truly disabled to the point of being worthy of remaining on the public relief rolls.

The physicians participating in this pilot study, by unanimous agreement, accepted no fees for this committee work.

The examinations revealed that only 97 of the 329 men were totally disabled. They also disclosed that:

Ninety-three were disabled for psychiatric reasons and 42 of these men had salvagable potentials.

Fifty-two had orthopedic problems and 38 of these were considered as having salvagable potentials.

Two hundred and four of these men had not gone beyond the 6th grade, and 30 of this number were illiterate.

One hundred thirty-seven had a mental age of eleven years or less.

Of the 97 totally disabled the average number of children was 6.3 per man.

The partially disabled had 5.3 dependents and those who were definitely able to work had only 3.4 children per man.

There was an area of this examination for which no definite figure or statistic could be properly drawn; this is the number of men whose disability depended to a degree on idleness. We had a strong awareness of idleness, and in a sense we believe it is a factor in all of the cases we reviewed.

*In graphs accompanying this report there are several instances where the total number of cases exceeds the 329 actually examined. This excess number represents charts reviewed without a physical examination of the patient.

Committee Members

The following members of the Kanawha Medical Society were appointed to conduct this study:

- **Edwin M. Shepherd, M. D., Chairman**
  W. D. Crigger, M. D.
  Edward Jackson, M. D.
  Harry A. Jackson, M. D.
  James B. Nichols, Jr., M. D.
  Frederick C. Reel, M. D.
  Carl J. Roncaglione, M. D.
  William C. Revercomb, Jr., M. D.
  George R. Rosenbaum, M. D.
  Page H. Seekford, M. D.
  Samir Shabb, M. D.
  Charles E. Staats, M. D.
  H. R. W. Vial, M. D.
  Charles C. Weise, M. D.
  Mr. Wilson Anderson, Legal Counsel

One case stands out as an example of almost pure response to idleness. In 1954 this man was put on relief as disabled because of a heart murmur. Actually, the mines "blew out" in his neighborhood and this was the handiest excuse for finding support for his family, admittedly in dire straits. He has not hit a tap of work since 1954. He has not grown a garden and has not attempted to get a job. He has even objected to walking to the post office to collect his welfare checks. His weight in 1954 was 160 pounds, his height 5′ 8″, and his blood pressure 118/60. In 1962 he weighs 230 pounds, his blood pressure is 190/110, and he walks with a cane because of lumbo-sacral strain. This man is now among the totally disabled. He might well be self-supporting if he had not had the opportunity to develop the habit of pure idleness.

It is notable that the totally disabled had the lowest average mental age (10), the lowest grade levels achieved in school and the largest number of children. Any notion of improving this group by education in the sense of book knowledge needs to be assessed with the recognition of the low caliber of mentality of those to be educated. Education here will need considerable thought. The mere learning of letters and numbers can

certainly be questioned as a way of getting these people to live on a higher social plane.

There is an area of neglect; not a deliberate wanton affair, but neglect because of the shifting of case loads, the shifting of responsibilities and the overwhelming load of trivial decisions which fall on the case workers charged with administering the care of these people.

A case in point is that of a man who in 1957 received a physical examination which showed emphysema and bronchiectasis. Referral to a chest specialist for pulmonary function and definitive therapy was very properly stated. A year later, without knowledge of the first doctor's examination, a second excellent physical check was made and the same recommendations given; two years later this was repeated. All three physical examinations gave evidence of great care, each showing a progressively disabled man. At no time was the suggested consultation obtained. At no time had the man had adequate or even semi-adequate therapy.

Another man had only a simple herniorrhaphy standing between him and return to work. He was on the rolls for two years before this surgery was approved and done.

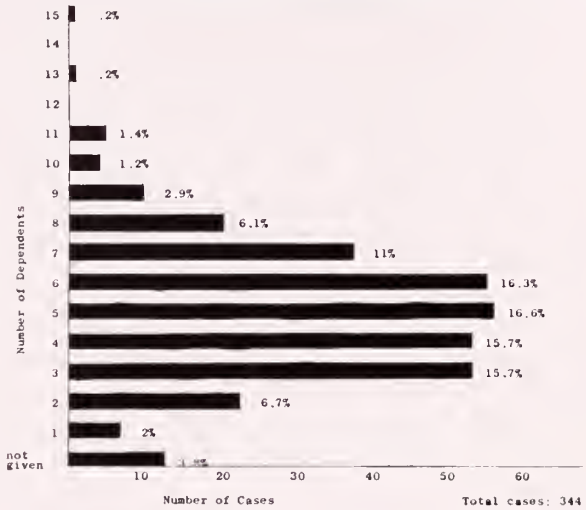
The shifting lines of responsibility, the shifting chain of authority among case workers whose primary mission is the socio-economic status of these people, apparently precludes an adequate development of a sense of urgency for obtaining follow-up on medical needs.

The result of our work with this survey has led the Kanawha Medical Society's committee to feel that we can render a very real service to the people supported by the Department of Welfare because of some disabling disease. We have set up a group under the chairmanship of Dr. William D. Crigger to carry out this work. Mr. Smith has verbally indicated his acceptance of the plan, but to date has not been able to give an official stamp of approval.

There are three basic problems presented to the reviewing authority for disability: (1) What is disability?; (2) How can the disability be remedied or cushioned and implemented to expeditious handling?; and (3) What to do with those who are well enough to work and not able to find employment because of partial impairment, either physical or mental.

A quick run down of those found disabled shows the largest group to be psychiatric, of low mental age, and poor school performance. The next largest group falls about equally to cardiovascular and musculo-skeletal diseases. Our re-

NUMBER OF CASES HAVING EACH PARTICULAR NUMBER OF DEPENDENTS



viewing group, therefore, includes a psychiatrist and a psychometrist, the latter from the Department of Vocational Rehabilitation. The Department of Vocational Rehabilitation is anxious to render a very needed service in this area, both in establishing the mental capacity and aptitudes of these people and also effecting a quick reference of those who show promise at the Rehabilitation Center for intensive help. An orthopedist and an internist round out the group with two general practitioners, one of whom very properly acts as chairman.

We consider this reviewing group a basic nucleus and have asked for the privilege of bringing in other specialists for temporary duty as needed. Thus can we assemble a number of cases that should have urologic consultation, or a number that have problems in the orthopedic field. Instead of one man in his specialty assuming the entire responsibility, we can have a conference and arrive at the best possible area of agreement for action. Amputations or surgery to the low back could most surely profit by this conference approach.

With this conference approach, the man with low mentality and physical equipment that could only allow skilled bench work or desk work is much more likely to be properly placed on the disabled list. We are immediately confronted with the fact that in our recent survey 106, or 32 per cent of the 329 examined, are in this category. If such a volume exists, and we believe it does throughout the State, some plan for help other than medical needs devising. Left alone these people will and do deteriorate to total disability. It is for this group that the sheltered workshop is a must. Some of them can be so

taught that they can get self-sustaining work and become independent. But we must face the fact that a number will remain wards of the State. Humanity dictates that they be kept busy for the preservation of their own health and self-respect.

The family physician who has a neighborhood practice needs the support of a reviewing conference. He needs it to get support for quick action in cases needing remedial surgery or other treatment. Without this support he can be and is pressured into hospitalizing cases that should be treated on an ambulant basis. This has led to deliberate restrictive action from the Department of Welfare and some cases really needing help are, for this reason, neglected.

The family physician is pressured to put his patients on the disabled lists so that they can get immediate aid. When a family is starving, an immediate decision is imperative. The family physician is repeatedly faced with the task of separating physical, psychologic and socioeconomic stresses in each patient he examines. The reviewing group can help differentiate between physical and psychologic versus socioeconomic problems so that the patient can receive aid from the appropriate agency. In so doing, individuals will not be denied the possibility of future retraining because they have been classified as "disabled." Also, the family physician will immediately have the opinions of various consultants to help in his management of those who are medically impaired.

Finally, the family physician can very properly be the one to protest any decision of the reviewing conference and appear as a member of the reviewing group when his patient is being reexamined.

The final authority for decision on disability cases rests in the hands of the appointed head of the Department of Welfare. We firmly believe that this authority belongs and should remain exactly where it is. We believe that the reviewing conferences of physicians should act only in advisory capacities. We further believe that the weight of their opinions, arrived at after a full discussion by such a wide representation of medical and psychologic disciplines, will rarely find other than agreement at all levels. We are equally aware that, in spite of our best efforts, we can be mistaken and that the set-up we recommend leaves a proper channel for appeal.

Following is the complete text of all letters, memoranda, and reports pertinent to this study:

Letter No. 1

FROM: W. Bernard Smith, Commissioner
West Virginia Department of Welfare
Charleston, West Virginia
February 5, 1962

TO: Robert C. Bock, M. D., President
Kanawha Medical Society

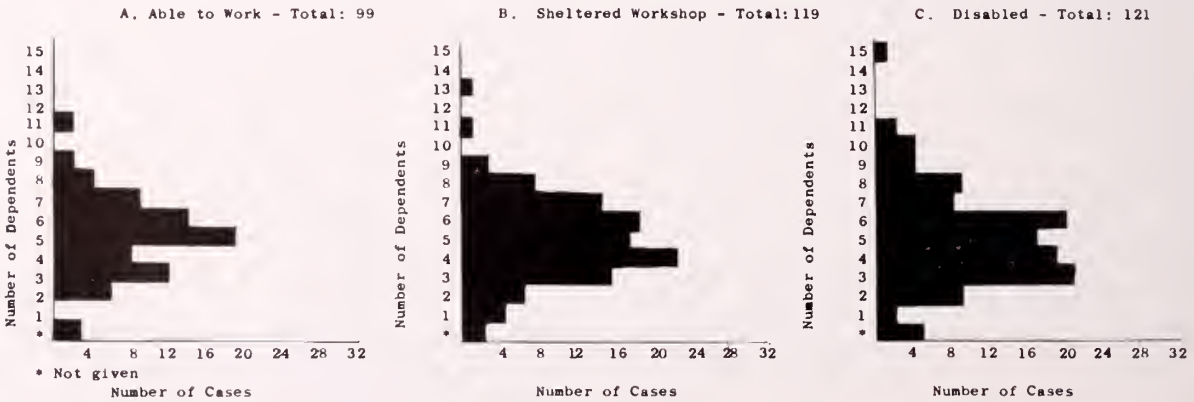
Dear Doctor Bock:

First I want to express my appreciation to you for discussing with me the problems relating to medical care in my office last Friday.

As I expressed to you then, the regular Aid to Dependent Children program and our Aid to the Permanently and Totally Disabled program comprise the greater portion of our permanent assistance case load. These cases comprise some 20,000 persons state-wide and I am in the process of obtaining figures from Kanawha County which I will make immediately available to you. These recipients comprise the greatest load upon the general medical program which is suffering financial problems along with the Medical Aid to the Aged program.

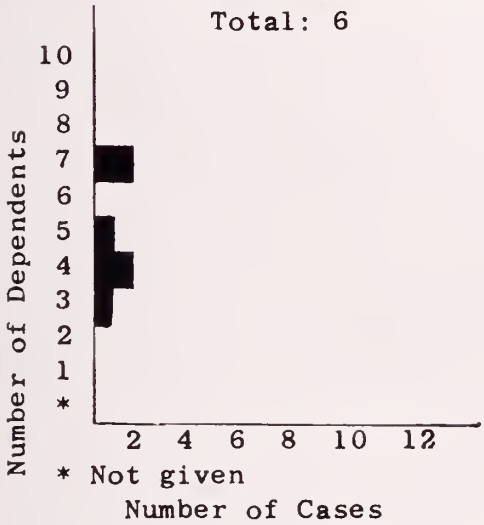
Most of these persons are eligible on medical examination, but such examinations have not

NUMBER OF CASES HAVING EACH PARTICULAR NUMBER OF DEPENDENTS PER EACH OF FIVE CLASSIFICATIONS



D. Capable of Rehabilitation
Total: 19

E. Temporary Assistance
Total: 6



been kept current nor are they rendered in great detail.

We would propose that with the cooperation of the Kanawha Medical Society that we establish Kanawha County as a pilot area to re-examine these recipients with the purpose of establishing (1) That only persons medically eligible for the program are receiving assistance; (2) That full medical reports be submitted on those found to be disabled but subject to cure if specific medical services could be extended. These reports should be in sufficient detail to enumerate the services which would be necessary.

We deem this program of major importance and the information gained therefrom could have far reaching affect upon the public welfare programs of the State of West Virginia for many years to come. In view of the importance we place upon this program I would propose that you determine the amount and method of payment which would be sufficient to acquire the services of the necessary medical personnel and which would allow them adequate compensation for their services.

I can certainly assure you and your group that I am extremely confident that if we pursue this program in the manner in which it can and should be pursued we should obtain results which could readily prove that if proper funds were made available for corrective services and proper examination, great savings to the taxpayers of our State could be expected in the long run. Not only would such savings result but many persons could be restored to active participation in the pursuits of life.

Please let me have the thoughts of your group on this matter and if acceptable to you, I will designate Dr. William C. Cook, Jr., and Mr. Calvin Cook of our Medical Division together with myself to work out specific details with you.

With sincere personal regards and best wishes, I am,

Very truly yours,

SIGNED: W. Bernard Smith,
Commissioner

Letter No. 2

FROM: Edwin M. Shepherd, M. D., Chairman
Medical Review Committee
Kanawha Medical Society

TO: W. Bernard Smith, Commissioner
West Virginia Department of Welfare
March 15, 1962

Dear Mr. Smith:

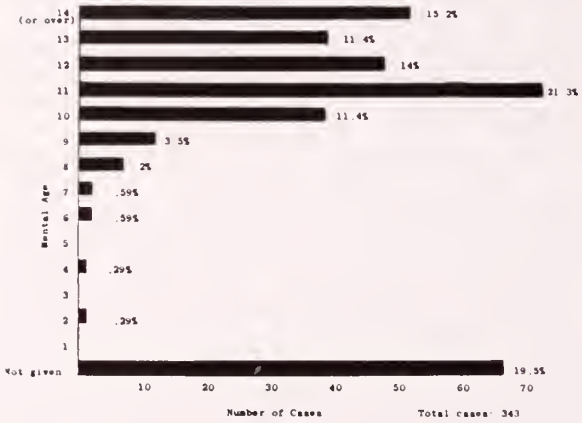
Enclosed is a resume of our notes on the meeting in which we formed the committee for re-examination of cases receiving assistance from the Department of Welfare on the basis of poor health. I will appreciate your reviewing this and in acknowledging its receipt let me know if there are any additions or deletions which should be made.

The committee appreciates your business-like approach to this problem and the dispatch with which we were able to set up the formula for this work.

Sincerely yours,

SIGNED: Edwin M. Shepherd, M. D.
Chairman

NUMBER OF CASES PER EACH MENTAL AGE LEVEL



Enclosure to Letter No. 2

On February 28, 1962, Mr. W. Bernard Smith, Mr. Calvin Cook, and Dr. William C. Cook, Jr., of the Department of Welfare met with 14 volunteers from the Kanawha Medical Society and agreed on the following methods of operation for a pilot program of re-examination of persons receiving assistance because of a medical disability.

Committee

The following volunteers make up the committee from the Kanawha Medical Society:

Edwin M. Shepherd, M. D., Chairman.
Mr. Wilson Anderson, Legal Counsel.
William D. Crigger, M. D.
Edward Jackson, M. D.
Harry A. Jackson, M. D.
James B. Nichols, Jr., M. D.
Frederick C. Reel, M. D.
William C. Revercomb, Jr., M. D.
Carl J. Roncaglione, M. D.
George R. Rosenbaum, M. D.
Page H. Seekford, M. D.
Samir Shabb, M. D.
Charles E. Staats, M. D.
H. R. W. Vial, M. D.
Charles C. Weise, M. D.

Additional members may be added as the committee deems it necessary to complete the examinations. Such persons will become a permanent part of the committee and shall receive the same rate of remuneration as the original members. At such time as the committee adds new members, the Department of Welfare will be so advised.

Cases to be Reviewed

The cases to be reviewed and examined in this pilot program will be all persons in Kanawha County, alphabetically, who receive assistance from the State Department of Welfare because of medical disability.

Clinic for Examinations

Arrangements will be made to use the facilities of a centrally located clinic.

Medical Records

After it is determined which cases must be reviewed, all medical records will be gathered to give a complete picture of the medical history. Only that portion of the hospital records necessary to give a complete history will be requested. The Commissioner of the Department of Welfare will make arrangements with the Hospital Council for reimbursement of the hospitals for making copies of records.

Case Workers and Clerical Worker

There will be at least one case worker and one clerical worker, from the Department of Welfare, present at the time of the interviews and examinations.

Lab Work

Routine lab work such as complete blood count, urinalysis, blood sugar, serology, non-protein nitrogen, blood urea nitrogen.

If the examining physicians deem it necessary to have more extensive lab work done to give a true evaluation of a person's medical status, such cases will be referred to a lab predetermined by the Department of Welfare and the fees for such lab work will be taken care of by the Department of Welfare. Only in those cases where the examining physicians' opinions differ, whether the extensive lab work is necessary or not, then will Dr. Cook be contacted for a decision.

Fees

The agreed fee is $20.00 per hour for each member of the Kanawha Medical Society Committee working on this pilot program, and such members that may be added (Ed. Subsequently, the physicians participating in this pilot study, by unanimous agreement, accepted no fees for this committee work).

Rules for Disability

Based on information from the Commissioner of the Department of Welfare, it is understood there are no predetermined rules for determining medical disability.

News Releases

It is agreed that all information regarding this pilot program be withheld until such time as it is completed. News releases shall be approved by both the Commissioner of the Department of Welfare and the President of the Kanawha Medi-

cal Society before they are released. It is also agreed there should not be any discussion of the work being done by the participants in this pilot program.

Contacts

Dr. William C. Cook, Jr., of the Department of Welfare and Dr. Edwin M. Shepherd of the Kanawha Medical Society are the designated contacts for any additional information regarding this pilot re-examination program.

It is understood that on completion of the pilot program of re-examinations of persons in Kanawha County receiving assistance because of medical disability the above agreements and the committee of the Kanawha Medical Society are dissolved. Any continuation of this work after the pilot study is completed will have to be negotiated at that time.

Letter No. 3

FROM: W. Bernard Smith, Commissioner
West Virginia Department of Welfare
March 26, 1962

TO: Edwin M. Shepherd, M. D., Chairman
Medical Review Committee
Kanawha Medical Society

Dear Doctor Shepherd:

I wish to thank you for your letter of March 15, 1962, regarding the pilot program in Kanawha County and the clear and concise resume of the meeting held in my office on February 28, 1962.

This report states clearly and concisely the arrangements agreed upon, and I am referring this to the medical division for its reference.

I wish to sincerely apologize for the delay in the initiation of this program, but we have incurred certain difficulties in arranging the procedure by which the cases can be referred to your committee. I certainly trust that this has been worked out satisfactorily between your committee and the medical division by this time.

I again wish to take this opportunity to express to you and Dr. Bock my sincere appreciation for the excellent spirit of cooperation shown by not only you, but the entire Medical Society of Kanawha County, and especially for the high caliber of men assigned to this project.

With sincere personal regards to you and Dr. Holt, I am,

Very truly yours,

SIGNED: W. Bernard Smith,
Commissioner

Memorandum

FROM: Mr. Calvin Cook
West Virginia Department of Welfare
June 13, 1962

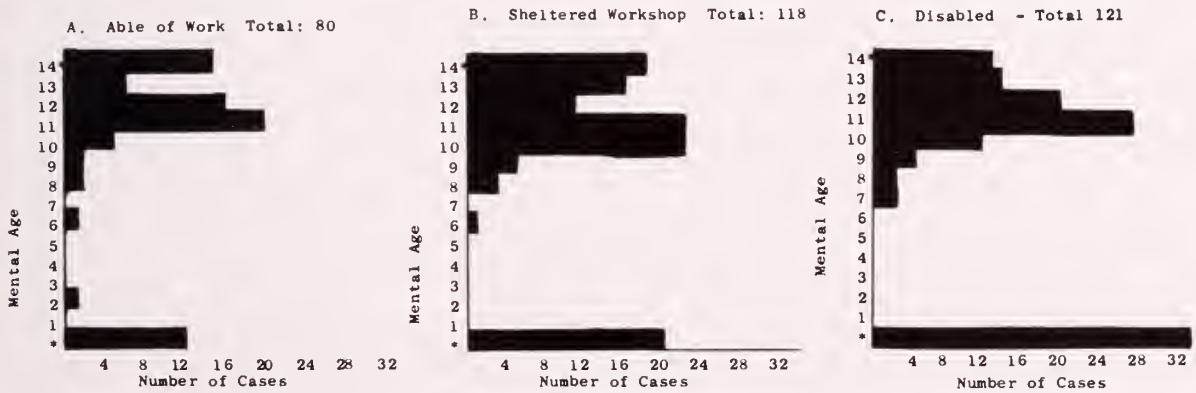
TO: Edwin Shepherd, M. D., Chairman
Medical Review Committee
Kanawha Medical Society

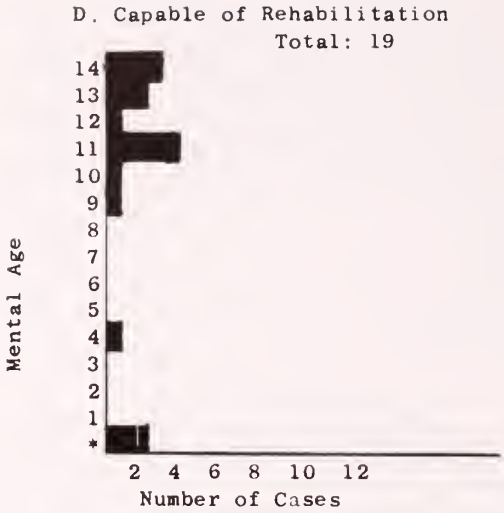
Outline of procedure to be followed in the Pilot Program in Kanawha County on ADC Based on Incapacity.

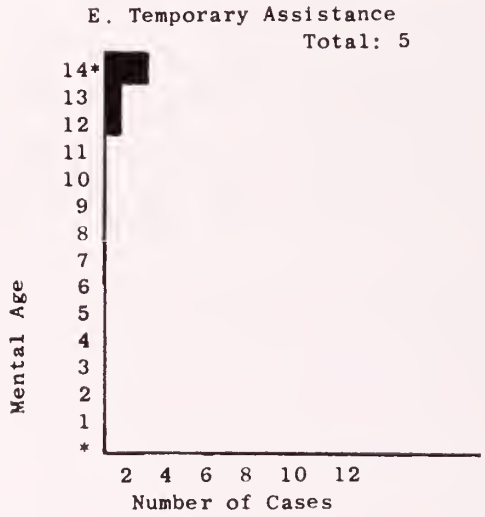
1. The Kanawha County staff will schedule the clients in for their original appointments with the physicians at the examining station at St. Francis Hospital, or elsewhere.

2. The case worker, whose clients are involved during a particular examining period, will complete the form as developed by the Physicians Review Committee and attend the clinic, taking along with her the "scan sheet" and the case records of the clients in her caseload who are to be examined. This means that perhaps two or three workers could attend the same clinic.

NUMBER OF CASES PER EACH MENTAL AGE LEVEL IN EACH OF FIVE CLASSIFICATIONS







14* = Mental age of 14 or over

* = Not given

3. If there are proper physicians on the panel so that they can make a determination of incapacity, they may go ahead and do so. However, if the panel of physicians determined that the person needs an examination by a physician who is not present at the time the client is at the clinic, it is the responsibility of the physicians to reschedule the person in for the time the particular physician would be present as a member of the panel.

4. If a worker feels that a client is so obviously disabled that there is no need for examinations, she can fill out the report and take it along with the case record to the clinic without scheduling the client in to the examining station. The panel physicians will review the report and the case record, and will decide whether to concur with the worker's evaluation of the disability, or if there is doubt on the part of the physician, the worker will be requested to schedule the client in for examination.

5. After a client has had all the examinations necessary to determine incapacity and if treatment has been recommended, this treatment can be provided if it comes within the scope of our present medical program. Treatment will not be provided, however, if it is not within the scope of the Department's present program. It will be the worker's responsibility to determine whether the recommended treatment can be secured from some other agency.

6. The Department will pay for x-rays and laboratory procedures at the rates set forth in our General Medical Services fee schedule.

7. Complete records must be maintained at all times showing the number of persons scheduled in for appointments, reasons for failure to report for examination, the number of clients examined, the results of the examinations, number for which rehabilitation services has been recommended, etc. This specific information will be most helpful to the Department when a request is made for additional medical services funds to carry this program through to a satisfactory conclusion.

Memorandum

FROM: W. Bernard Smith, Commissioner
West Virginia Department of Welfare
June 21, 1962

TO: Calvin Cook, Dr. William C. Cook, L. L. Vincent, and Dr. E. M. Shepherd

RE: Clarification of Procedures regarding Pilot Medical Study in Kanawha County

It has recently come to my attention that there seems to be some misunderstanding between members of the Medical Review Committee and members of this Department regarding procedures to be used in the successful fulfillment of the purposes of this program. I therefore deem it necessary to set forth my understanding of the agreement between me as Commissioner of the Department of Welfare and Dr. Shepherd representing the Kanawha County Medical Society. You will note that a copy of this memorandum is being sent to Dr. Shepherd and I certainly hope that if any misunderstanding exists it will be clarified immediately.

Purposes:

1. Selected cases will be referred to the Medical Committee for determination of those cases

in which the files contain insufficient information to make an accurate medical determination of eligibility.

2. Those cases in which insufficient medical information exists the Medical Committee will request that they be referred to the Committee for examination.

3. Upon appearance for examination, three steps can be taken by the examining physicians:

A. Obvious case of eligibility calling for a medical report to be submitted and filed in the case record.

B. Obvious case of ineligibility and a medical report will be submitted for consideration by the Departmental medical staff.

C. Need for additional diagnostic examinations. It is understood that if such should be the decision of the original examining physician, this will be noted and referred to the specialist on the Committee to examine this individual. An Individual recipient regarding whom the determination is made by the initial examining physician will be rescheduled to appear at the clinic upon a day when the specialist will be present. Upon examination by the specialist a medical report will be filed stating what, in his opinion, medical treatment can be given which will rehabilitate the recipient medically.

It appears that the basic misunderstanding is in the purpose of this pilot program. The Department hopes to have sufficient medical information on a sufficient number of cases to substantiate our belief that if sufficient medical treatment were given to a specific class of recipients they could be rehabilitated to a normal, active life. We regret that in many instances at present these medical services could not be extended to the individual, but we need a medical statement as to what is necessary to aid us in obtaining sufficient funds to allow us to provide these services.

If a report is submitted by the Medical Committee suggesting treatment available within the present policy of the Department, this can be rendered.

Payment for services can be rendered for clinical and pharmaceutical needs if the Medical Committee states that it is necessary to obtain a complete diagnosis and necessary to give the Department a complete medical statement of those medical services which can be extended to medically rehabilitate the individual.

Unfortunately, because of the limited funds available for remedial treatment, it will be impossible to follow through with many of the recommendations at the present time. However, upon receipt of the final report and receipt of statistics compiled by the Department, we will attempt to place into effect as much of the remedial treatment as is financially possible.

Both the Department and the Medical Committee should keep in mind that the purpose of this program is not actually to provide medical rehabilitation, but to determine the type of medical rehabilitation necessary.

The Department is instructed to take all necessary steps to make the necessary changes to comply with the purposes of this program.

(The examinations were conducted at the Herbert J. Thomas Memorial Hospital, St. Francis Hospital, and Staats Hospital; the following is a model agreement, the other two were verbal:)

Letter No. 4

FROM: A. Spates Brady, Jr., M. D., Member
Executive Board
St. Francis Hospital
May 12, 1962

TO: Edwin M. Shepherd, M. D., Chairman
Medical Review Committee
Kanawha Medical Society

Dear Doctor Shepherd:

This letter will confirm the conversation and agreements requested by your committee, on Kanawha County Evaluation of Clients of the D.P.W.-A.D.C. Program, between Sister Thomasina, Administrator of St. Francis Hospital, Dr. E. M. Shepherd, Chairman of Committee, and Dr. A. Spates Brady, member Executive Board of St. Francis Hospital, on May 11, 1962.

Your request for an examining area is agreed as follows:

I—1. Examinations will be confined to the Nurses Recreation Room, each Friday between 9:00 A. M. and 3:00 P. M.

2. The Hospital will provide four examining cubicals equipped with draping linens. No diagnostic equipment will be provided.

3. Laboratory work is immediately available in the hospital when required, and will be promptly reported for review charts.

4. Electrocardiograms will be immediately available, read, and reported on the day of examination. Matted reports will be mailed to the committee chairman.

5. Sufficient interview tables and chairs will be provided.

II—Agreed procedure for submission of invoices and payment for services.

1. Requisitions for laboratory work and electrocardiograms will be identified by "Ordered by State D.P.W.—Kanawha Medical Society Committee."

2. Invoices for laboratory work and electrocardiograms will be submitted directly to Mr. Cook.

III—It was agreed that the hospital should be reimbursed for costs of setting up and janitor services necessary in maintaining the area for examinations and laundry in the amount of $10.00 for each day of use.

IV—Case Load and Examinations:

1. It is the opinion of the undersigned that the case load of 400 clients can be properly examined with four physicians at the rate of 20 cases each Friday.
2. The enclosed exhibit examination has been found to be irreducible minimum source record for consultative medical examination by the Rehabilitation Department of Social Security. It is recommended. The coded numerical evaluation scale, about which we talked is not recommended. It introduces variables and imponderables that are extraneous and artifical. The best review report is one in which the reviewer can draw a conclusion based on a descriptively accurate account as to duration, diagnosis, opinion of the examining physician, present status, and compliance with or refusal of remedial medical or surgical procedures designed to restore the client to a gainful occupation or terminate progressive impairment of function.

If I can be of any further assistance, please let me know.

Respectfully,

SIGNED: A. Spates Brady, Jr., M. D.

Letter No. 5

FROM: Edwin M. Shepherd, M. D., Chairman
Medical Review Committee
Kanawha Medical Society
October 10, 1962

TO: W. Bernard Smith, Commissioner
West Virginia Department of Welfare

Dear Mr. Smith:

In the course of our examination of patients sent to us by the Department of Welfare, we became aware of two areas where administrative changes only would expedite handling of medical cases.

The first is in the organization of the patient's files. We recommend that color coding be instituted throughout these files to facilitate the prompt location of any medical data needed.

Our second observation was a lack of continuity in medical followup. This could possibly be remedied with the present staff by the studied reassignment of patients in priority groupings.

Very truly yours,

SIGNED: Committee Members
Edwin M. Shepherd, M. D.,
Chairman

Letter No. 6

FROM: Edwin M. Shepherd, M. D., Chairman
Medical Review Committee
Kanawha Medical Society

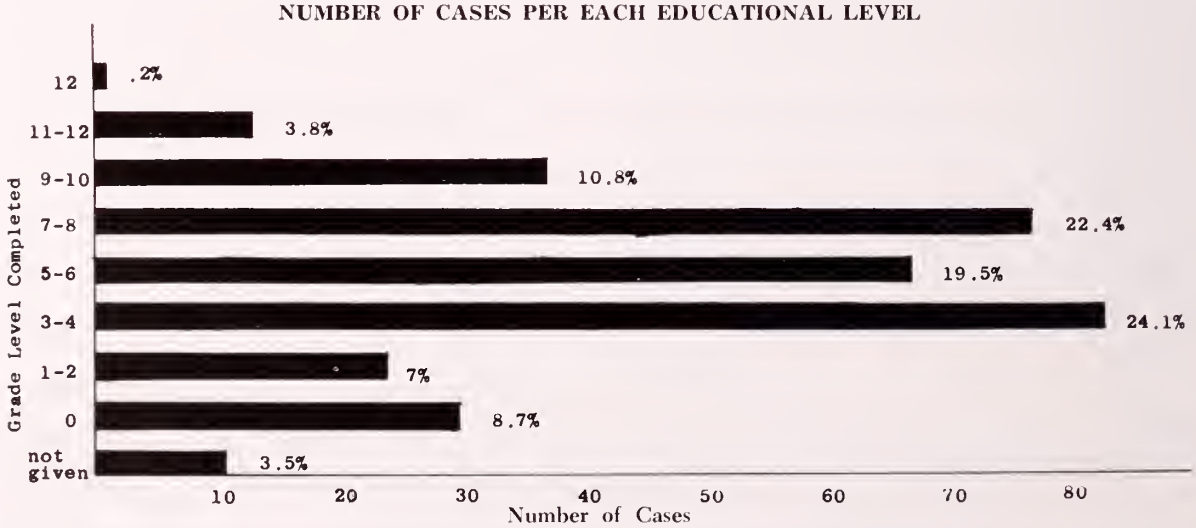
TO: W. Bernard Smith, Commissioner
West Virginia Department of Welfare
October 10, 1962

Dear Mr. Smith:

The committee of the Kanawha Medical Society has examined 329 patients sent to it by the Kanawha County Division of the West Virginia Department of Public Welfare in accordance with this special project assignment discussed in your office on February 28, 1962.

Each patient was examined and his file surveyed by one of the examining members of the committee. Appropriate specialists made examinations as needed. Laboratory work, x-rays, and electrocardiograms were performed as indicated. These examinations included a psychological

NUMBER OF CASES PER EACH EDUCATIONAL LEVEL



evaluation of intelligence. At the end of each week of examinations the committee met and evaluated the findings. A decision was reached in a majority of cases in these meetings. However, an occasional case was sent back for restudy.

The following are our findings:

Mental Age and Scholastic Achievement

Results of the "Kent Test" are as follows:

	3 years 1	9 years 12
	4 years 1	10 years 39
Mental Age	5 years 0	11 years 73
	6 years 2	12 years 48
	7 years 2	13 years 39
	8 years 7	14 years 52

A study of the files showed the following scholastic achievement:

Illiterate—30

Grades Completed:	Not beyond second grade	24
	Not beyond fourth grade	83
	Not beyond sixth grade	67
	Not beyond eighth grade	77
	Not beyond tenth grade	37
	Eleventh and twelfth grades	13
	Beyond 12th grade	1

An impairment of sufficient magnitude to render the patient totally disabled was found in 96 patients. Of this number

25 were impaired due to cardiovascular disease
1 was impaired due to genitourinary disease
5 were impaired due to gastrointestinal disease
14 were impaired due to musculoskeletal disease
51 were impaired due to neuropsychiatric disease

The average mental age of those totally disabled was 10 years.

The mean scholastic achievement of those totally disabled was from fifth to eighth grade.

The total number of dependents in this group of patients was 615.

There were 106 whose impairment was insufficient to preclude work, but sufficient to make it difficult to find gainful employment. This group could function in the atmosphere of a sheltered workshop. With proper rehabilitative efforts some of this group could be restored to full employment.

Eye, ear, nose, and throat impairment	5
Cardiovascular impairment	32
Genitourinary impairment	0
Gastrointestinal impairment	1
Neuropsychiatric impairment	42
Musculoskeletal impairment	38

NOTE: Do not attempt to justify above figures by simple addition back to the number disabled as some of these patients have multiple disabilities.

The average mental age of this group was 13 years.

The average scholastic achievement of this group was to the fifth to sixth grades.

The total number of dependents in this group was 565.

In the examination of 116 patients we were unable to find sufficient impairment to justify classifying them as disabled. The average mental age of this group was 11 to 12 years. The average scholastic ability of this group was to the seventh to eighth grades. The total number of dependents of this group was 404.

Our committee will gladly confer with you or your staff to amplify our findings or to discuss other phases of our study.

It is hoped that the conclusions reported herein will be of benefit to you in evaluating the medical aspects of the files which we reviewed.

Respectfully submitted,

SIGNED: Committee Members
Edwin M. Shepherd, M. D.,
Chairman

Letter No. 7

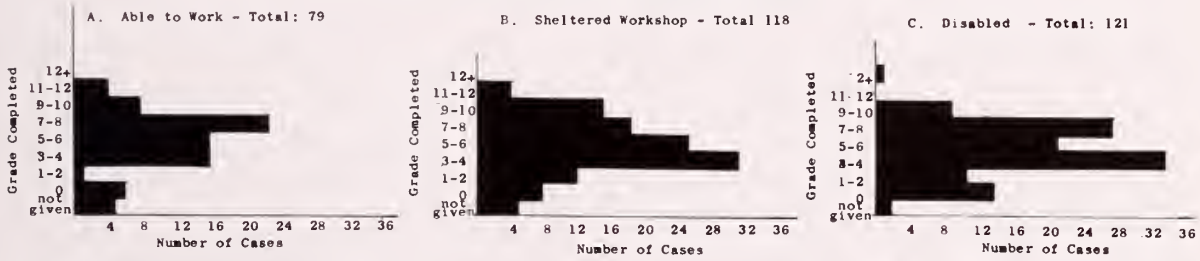
FROM: Edwin M. Shepherd, M. D., Chairman
Medical Review Committee
Kanawha Medical Society
October 22, 1962

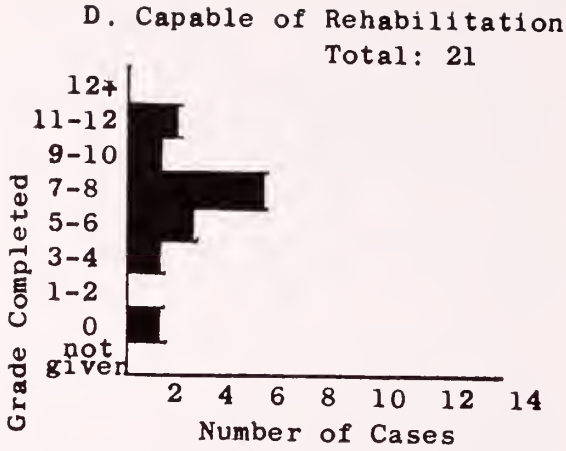
TO: Robert C. Bock, M. D., President
Kanawha Medical Society

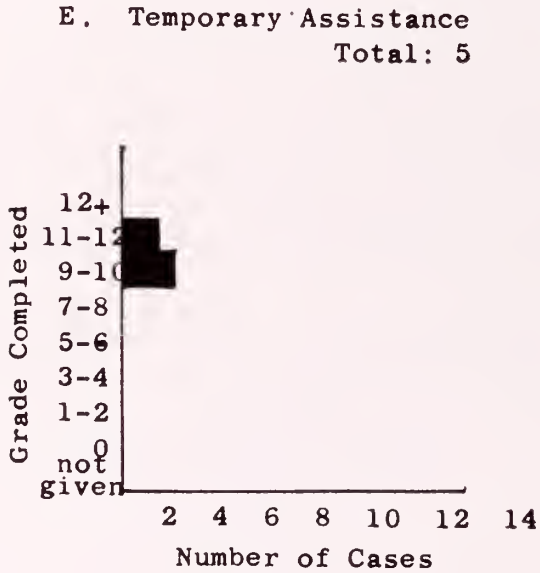
Dear Doctor Bock:

The Kanawha Medical Society Committee working with the West Virginia Department of

NUMBER OF CASES PER EACH EDUCATIONAL LEVEL IN EACH OF FIVE CLASSIFICATIONS







Welfare on those men who are listed on Aid to Dependent Children because of disability has completed its work and we submit the following recommendations for the continuation of this examining effort.

The men from the Kanawha Medical Society to continue this work are listed as follows: William D. Crigger, M. D., Chairman, Carl J. Roncaglione, M. D., Charles C. Weise, M. D., Harry Jackson, M. D., Page Seekford, M. D., and Charles Staats, M. D.

We propose that this group be considered a nucleus and be empowered to call in additional consultants or to request others in their respective fields to fill in in the event of their absence. We propose that a token fee of $25.00 per doctor be charged for each session held during the first year at the end of which time a re-evaluation of the service be made and a realistic fee schedule for services rendered be instituted.

It will be the function of this group to evaluate all of the people who are considered disabled and for this reason listed on Aid to Dependent Children and Aid to Permanently and Totally Disabled. In line with this evaluation they will act as consultants to any doctor who having examined one of these patients for the Department of Welfare finds himself in need of further opinions. For emphasis let it be stated that it is not the function of this group to make primary examinations. This we assume will be done as it has always been done by the physicians who normally handle these people and know them best. It will not be a function of this group to undertake treatment in any form. It will be a function of this group to inquire as to what treatment is being done and to expedite the proper handling of these people whose ills require urgent attention.

It is to be hoped that this group can find a ready cooperation with the Division of Vocational Rehabilitation and get those persons for whom this service is needed into the hands of this organization with a minimal waste of time and effort. We propose that for the first year of this group's function the secretarial services be furnished by the Kanawha Medical Society. The place of meeting and the detail of the frequence should be decided by the active group.

Respectfully submitted,

SIGNED: Committee Members
Edwin M. Shepherd, M. D.,
Chairman

Letter No. 8

FROM: Edwin M. Shepherd, M. D., Chairman
Medical Review Committee
Kanawha Medical Society
October 29, 1962

TO: W. Bernard Smith, Commissioner
West Virginia Department of Welfare

Dear Mr. Smith:

This is a supplementary letter to the one written to Dr. Bock of which you have a copy.

We would like to have a member of the social service staff of Vocational Rehabilitation, who is skilled in psychometric examining, to sit as a member of the reviewing group and to perform two functions, (1) to provide the group with an assessment of the intelligence level of the per-

son being examined, and (2) to act as liaison between the reviewing group and Vocational Rehabilitation. He could expedite people eligible for vocational rehabilitation training into the Center or whatever area seems to be indicated.

We have already discussed this cooperative effort with Mr. Earl Wolf, and he feels that it could be done.

Respectfully submitted,
SIGNED: Committee Members
Edwin M. Shepherd, M. D.,
Chairman

'But Have Not Love'

Last spring, upon reading my son's college application, I learned for the first time why he wanted to be a doctor. In essence, he stated that he wanted to study Medicine because it is an intellectual challenge and because it offers the opportunity to be of service to one's fellow man. It struck me as more than coincidental that he feels now just as I felt when I entered college 30 years ago. Despite the feeling of many doctors that Medicine has "changed," the same reasons, the same desires, the same attractions which have, since the beginning of time, motivated young men to study Medicine, still exist. Any doctor worthy of the name must be basically a student and he must have a full measure of compassion in his heart and love for his profession and for his patient.

Not so long ago the practice of Medicine was almost all art. Because a doctor had little to offer but a compassionate heart, sympathy was the principal ingredient in his armamentarium, with the result that while he was highly regarded by his patients, the results of his treatment left much to be desired. More recently, in the human experimentation laboratories of Nazi Germany, the world was afforded a glimpse of what Medicine would be like if it were all Science and no heart.

While love, or compassion, one of its many synonyms, is a difficult word to define, no better definition is to be found than that which appears in the Bible in the thirteenth chapter of the First Letter of Paul to the Corinthians: "If I speak in the tongues of men and angels, but have not love, I am a noisy gong or a clanging cymbal. And if I have prophetic powers, and understand all mysteries and all knowledge, and if I have all faith, so as to remove mountains, but have not love, I am nothing. . . . Love is patient and kind; love is not jealous or boastful; it is not arrogant or rude. Love does not insist on its own way, it is not irritable or resentful; it does not rejoice at wrong, but rejoices in the right. . . ."

This is a beautiful description of a *personal* relationship. Indeed, it is difficult to imagine love in any other way but as a personal relationship. One of the greatest problems facing the medical profession at the present time is the preservation of this aspect of the practice of Medicine. If our sons are to have the opportunity of enjoying the great satisfaction of practicing Medicine as we have, we cannot permit our profession to become federalized, unionized, mechanized or in any other way impersonalized. Love begets love, compassion begets compassion, interest begets interest. In the long run, the best loved and most successful doctor is usually the one who gives the most of himself.

With the explosion of knowledge which we have witnessed in this century, the future of Medicine as a science is assured. Whether Medicine as an art survives depends on how much heart we put into its practice. As long as young men still can find in the practice of Medicine not only an intellectual challenge but a satisfying avenue for service to mankind, for the expression of compassion innately existing in the hearts of all good men, the future of the medical profession is secure.—Robert E. Zellner, M. D., in the Journal of the Florida Medical Association.

The President's Page

Charles Lively Memorial Scholarship Fund

THE year nineteen sixty-two will be remembered as the most successful in the long history of the West Virginia State Medical Association. If all the events which transpired were recounted and recorded it would take many pages in *The Journal.* The combined efforts of all members of our Association resulted in an efficient and workable MAA Program. This, plus our successful efforts against the King-Anderson Bill, brought all West Virginia physicians closer together and strengthened our Association immeasurably.

I would be remiss, however, if I did not point out one undertaking of our Association in which we have not received the cooperation necessary to achieve our anticipated goal. Indeed, in my judgement, we have come close to failure in this undertaking. I refer to our efforts during the past year to solicit voluntary contributions to the Charles Lively Memorial Scholarship Fund.

The House of Delegates of your Association in 1961 voted unanimously to change the name of the Scholarship Fund of the West Virginia State Medical Association to the Charles Lively Memorial Scholarship Fund and a resolution was adopted to invite active voluntary contributions, to this fund. This action was taken to produce a living memorial to the memory of our late beloved and revered executive secretary who devoted so much of his life to the efficient handling of the affairs of our State Association. Those of us who knew him and worked with him shall never forget his untiring efforts and devotion to our cause, and so it is we wish to forever keep his name alive and with us.

You are aware that $6 of the annual dues of each active member is earmarked for the Scholarship Fund. These funds have made it possible to establish 2 four-year scholarships annually to deserving students enrolled in the first-year class at the West Virginia University School of Medicine. Each of these scholarships has a value of $4,000.

I have heard it said many times that "this is the most successful and beneficial program yet established by the State Medical Association." I wholeheartedly agree with this statement and I know Charles Lively shared this belief.

Late last year the Committee on Medical Education, Hospitals and Scholarships decided to make an appeal to the membership of the Association for voluntary contributions to the Scholarship Fund. To date approximately $6,000 has been contributed. Nearly one-half of this was donated by physicians in the Brooke and Ohio County Medical Societies—and a sizable amount of the balance from several individual physicians throughout the State.

It is my personal belief and desire that each of us will want to donate to this worthy program. I like to think our original undertaking did not accomplish the desired goal because we did not have an organized drive, and many of us failed to contribute because we were not contacted by anyone in our local Society. It is for this reason that I will appoint, within the next few weeks, one or two members from each component society to solicit contributions for the fund. It shall be the responsibility of each of these men to contact personally each of their colleagues and I am confident that the response will be most gratifying. (It is the opinion of legal counsel that contributions are tax deductible).

The importance of our providing financial assistance to deserving young men and women enrolled at the West Virginia University School of Medicine cannot be minimized. I urge the members of the State Medical Association and the Woman's Auxiliary to accept this responsibility and work diligently to help make possible the expansion of our present medical scholarship program.

L. J. Pace, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston 24, West Virginia. Phone 346-0551.

EDITORIALS

HEALTH CARE IN RURAL AREAS

Physicians are reminded daily of the scarcity of doctors in rural, suburban, and urban West Virginia. Yet our ratio of population to physician is only slightly higher than the ratio throughout the U. S. A. A majority of physicians go into specialty practice and locate in urban areas. These specialists serve the surrounding rural communities as well as the people in their own area. Any medical comparison of rural and urban practice embraces more factors than population.

A recent and highly publicized survey indicates there are 50 towns of 500 or greater population in West Virginia which do not have a physician within a five-mile radius. Such a statement requires careful analysis. The density of rural population in West Virginia is 48 per square mile and most rural areas in West Virginia, excluding the larger towns, cannot economically support a physician. Rural population is steadily diminishing and showed a 12 per cent loss in the 1960 census. Rural mileage is important only when stated in time of transportation and the rural physician can travel 5 miles in less time than it takes the city doctor to drive from office to home or hospital. Many rural residents have frequently gone to the city for elective medicine and will continue this practice.

There is now a determined effort to interest the West Virginia medical student in rural practice. The scholarships of the West Virginia State Medical Association are based on a requirement of 4 years rural practice. Only time will indicate whether this movement will be able to balance the counter attraction of city residence, specialty practice, and the cultural, religious, educational and medical advantages that are available only in cities.

It is the contention of some West Virginians that the medical needs of rural areas can be solved by an influx of foreign graduates. West Virginia Medicine will welcome such a solution providing the foreign graduate is a capable physician and can comply with the same degree of pre-medical and medical excellence required by the West Virginia University School of Medicine as stated in the Medical Practice Act.

Should the requirements of the foreign graduate be lowered to attract more physicians to rural West Virginia? Would this create a degree of sub-standard medicine in rural West Virginia?

Let's look at the record of foreign graduates in the U. S. In 1961 the failure rate of foreign medical graduates, after one to several years of medical training in the U. S., was 29 per cent as against the casualty rate of the American school graduate of 2.8 per cent. A special examination

was devised by the Education Council of Foreign Medical Graduates to screen physicians abroad and in the U. S. Only 35.6 per cent were able to obtain the standard certificate of the E.C.F.M.G., and 27.9 per cent were given a temporary certificate. This certificate is necessary to secure a position in any hospital approved by the American Hospital Association. This is an examination which can be passed by all recent American graduates.

It seems that before accepting a questionable solution for better medical care for our rural population, some new techniques might be given consideration. Rural communities can help themselves by building suitable clinic facilities, by providing transportation to bring sick patients to the physician's office, by utilizing the part-time services of neighboring physicians and by wider use of the multiphasic screening facilities of the Health Department. It is doubtful if any system of medicine can deliver immediate home service to people in sparsely settled areas.

HENRY D. HATFIELD, M. D.

When Dr. Henry Drury Hatfield died on October 23, his passing sounded the death knell for an era he had outlived—the age of the mountain physician, the rugged individualist in the political arena, the social conscientiousness borne of personal rather than corporate or governmental recognition of mankind's needs. A completely outspoken man, Doctor Hatfield never ran with the pack but followed unswervingly the course which to him seemed to be right and honorable.

Few men, even in a long lifetime, could lay claim to eminence in so many fields. Doctor Hatfield found rewarding the contributions he made to society in medicine and the art of politics. He was prominent as surgeon, West Virginia Governor and U. S. Senator.

Doctor Hatfield was as well known in mountain fastness as on the floor of the United States Senate. And he was the same forthright personality in both roles. As a young physician he established his reputation in the Southern West Virginia coal fields. He was not only physician but counsellor and provider to the poverty-stricken.

Doctor Hatfield had a reputation as individualist in the U. S. Senate and long after his tenure there was highly regarded as a statesman for the Republican Party. Doctor Hatfield was formidable in demeanor. A huge man, he was stripped of pretensions and nonsense. He could be gruff or forbidding. But he was not without humor and a twinkling eye often belied the apparent gruffness. When he thought the occasion demanded it, he could bellow, and at the same time be the soul of gentleness with a sick child.

The remarkable thing about him was not that he was surgeon or senator but that he was Henry Hatfield—the taciturn mountaineer, the kinsman of "Devil Anse," his own man answerable to his own conscience, the complete individualist. Such men are rare, their contribution great. Dr. Henry Drury Hatfield was a different kind of man. The wide community he served is the better for that difference.—*The Huntington Herald Dispatch.*

EFFECT OF ISCHEMIA ON THE BRAIN

The cells of the cerebral cortex are the least capable of withstanding oxygen want than any cells in the body. Certain tissues, notably cartilaginous, can withstand total deprivation of oxygen for several hours without suffering any apparent deleterious effects, whereas the brain can withstand oxygen want for only a few minutes.

The effect of anemia on the brain was studied as early as 1836 by Sir Astley Cooper;[1] other early studies were those of Hill[2] in 1896, and later those of Crile and Dolley[3] in 1908. Since that time this subject has engaged the attention of many workers.

Even a short interruption of the circulation of the brain is of serious import. As emphasized by Kety[4] interruption of the circulation of the brain for only 5 seconds produces noticeable changes in neurologic function and consciousness. Cerebral ischemia for a period of only a few minutes may produce irreversible damage to the cells in the cerebral cortex. The anatomic changes which may take place may be of various degrees of severity, such as capillary hemorrhage, clouding of Nissl's substance, shrinkage of the neuron, loss of stainability, and still other neuropathologic changes have been described.

Van der Molen[5] in 1939 reported that cortical cell changes may occur at partial pressures of oxygen equivalent to about 28,000 feet, and some of these changes may be irreversible. An unacclimatized man cannot live but for a short time at 28,000 feet, indeed, he can probably live for but a few minutes at 25,000 feet.

Rosen *et al.*[6] in 1943, working with 126 normal, young male subjects, and using an inflatable cervical cuff found that on the average unconsciousness was produced in 6.8 seconds. Shutting off the blood supply momentarily to the brain, of course, produces no lasting effect on the delicate cortical cells.

Unfortunately there are several rather common conditions which may produce irreversible changes in the cells of the cerebral cortex. A nearly fatal hemorrhage may do lasting harm. Several such cases have been reported in the literature. Severe carbon monoxide poisoning, too, may produce this grave effect. Drinker[7] many years ago pointed out that individuals who have been exposed to severe carbon monoxide poisoning may for all practical purposes be considered to be decerebrated.

Another condition which may produce irreversible changes in the cells of the cerebral cortex is nitrous anesthesia when given in dangerous concentrations over a long period of time. Many such cases have been reported in the literature, but fortunately the danger of nitrous anesthesia is now pretty well known.

Individuals, then, who have been exposed to any one of the three conditions outlined above may have suffered irreparable damage to the cerebral cortical brain cells. Such people may suffer from marked personality changes or show grave neurologic manifestations. Such patients may live, or rather exist, for years. They can be hardly said to live since, for the main part, they are doomed to lead a vegetative existence for the remainder of their lives.

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SUCCESSFUL PG COURSE IN BECKLEY

For some years the practicing physicians of West Virginia have been looking forward to some fruit from their labors in establishing a four-year School of Medicine in West Virginia. It was agreed that postgraduate instruction for the physician must await the completion of the school of undergraduate training.

The first formal graduate session of the WVU School of Medicine was held in Beckley, October 9-10. The program was conducted by Dr. Charles E. Andrews, Associate Professor of Medicine, who occupies the West Virginia Tuberculosis and Health Association's Chair of Pulmonary Diseases. It was fitting that the subject, "Current Concepts of Pulmonary Diseases," was a topic in many angles peculiar to West Virginia industry.

The postgraduate course attracted 60 registrants and the attending physicians consisted of internists, surgeons, general practitioners, residents, interns and students. The program was co-sponsored by the West Virginia Thoracic Society and the West Virginia Tuberculosis and Health Association which contributed support and funds to make this symposium an outstanding success.

The subjects concerned tuberculosis, bronchitis, silicosis and other pulmonary occupational diseases, emphysema and cancer of the lung.

The discussants were Doctor Andrews, Dr. William S. Blakemore of the University of Pennsylvania School of Medicine, Dr. William E. Ruth of the University of Kansas, Dr. William W. Stead of Marquette University and Dr. Bernard Zimmermann of the WVU School of Medicine.

Local talent included Drs. Preston C. Davis, Albert D. Kistin and Werner A. Laqueur, members of the staff at the Beckley Memorial Hospital, and Dr. Richard V. Lynch, Jr., of Clarksburg.

The program consisted of an informal discussion with questions from the registrants. The friendly, instructive atmosphere contributed to the success of the meeting.

This was an outstanding first in West Virginia medical history and indicates the excellent instruction West Virginia physicians may expect from our School of Medicine in Morgantown.

GENERAL NEWS

Fall Meeting of the Council Held In Charleston on Nov. 4

The fall meeting of the Council of the West Virginia State Medical Association was held at the Daniel Boone Hotel in Charleston on November 4, 1962, with the Chairman, Dr. D. E. Greeneltch of Wheeling, presiding.

Doctor Greeneltch introduced the three new members of the Council, Drs. Charles L. Leonard of Elkins, I. Ewen Taylor of Huntington, and William B. Rossman of Charleston.

Election of Honorary Members

The Council elected the following physicians to honorary life membership in the West Virginia State Medical Association:

Society	*Physician*	*Address*
Ohio	E. Lloyd Jones	Wheeling
	William P. Sammons	Wheeling
Cabell	Charles E. Hamner	Charleston

New Committee on Athletic Injuries

Dr. L. J. Pace, the President, reported that several physicians throughout the state had expressed an interest in the establishment of a Committee on Athletic Injuries. He further reported that it was his desire to name as chairman of the committee, Dr. Richard W. Corbitt of Parkersburg.

The Council went on record unanimously as approving the establishment of a Committee on Athletic Injuries as a special committee of the Association until such time as the By-Laws can be amended to make it a standing committee. (See article elsewhere in this issue of *The Journal*).

Publication Committee Member Reelected

Dr. E. J. Van Liere of Morgantown was reelected a member of the Publication Committee for the term ending December 31, 1969.

Report of Legislative Committee

Dr. Frank J. Holroyd of Princeton, Chairman of the Legislative Committee, stated that a meeting of his committee had been held in Charleston late in September for the purpose of discussing proposed legislation on the state level.

He discussed briefly the proposed Medical Examiner's Bill, State Health Department budget, changes in the Mental Health Law and a bill concerning autopsy consent.

Doctor Rossman presented a report on the proposed mental health legislation and stated that a rough draft of the bill had been prepared by the Association's Mental Health Committee, the State Department of Mental Health, and the State Association for Mental Illness.

It also was reported that several changes will be considered prior to preparing the final draft of the Medical Examiner's Bill which will be introduced in the 1963 session of the Legislature.

Dr. D. E. Greeneltch of Wheeling, second from left, Chairman of the Council, is shown with the three new members who were introduced at the fall meeting in Charleston on November 4. The new members are, left to right, Drs. Charles L. Leonard of Elkins, William B. Rossman of Charleston, and I. Ewen Taylor of Huntington.

AMPAC

Doctor Pace was called upon to discuss the activities of the American Medical Political Action Committee. He stated that there had been considerable discussion among the physicians on the subject of AMPAC during his official visits to component societies throughout the state.

He pointed out that the Association's House of Delegates had approved a resolution during the 95th Annual Meeting at The Greenbrier urging physicians to "act as individuals in supporting the American Medical Political Action Committee, with active participation in political-economic activities of that organization in their communities and congressional districts."

Following considerable discussion, the Council went on record as approving the formation of an AMPAC organization in West Virginia.

MAA Program

Dr. George R. Callender, Jr., of Charleston, Chairman of the Joint Conference Committee, appeared before the Council on invitation of the Chairman and discussed operation of the MAA and GMH programs.

Doctor Callender stated that his Committee had met periodically with State Welfare Commissioner W. Bernard Smith since early in the spring. He also stated that the members of his committee and officials of the Department of Welfare were pleased with the work of the review committees on the district level.

It also was reported that Doctor Greeneltch had been invited to participate in the Fifth Annual AMA Medical Services Conference in Los Angeles on November 25, 1962. The program was devoted to a discussion concerning implementation of the Kerr-Mills Law throughout the country.

Report of Tuberculosis Committee

The Executive Secretary reported that Dr. Ralph H. Nestmann of Charleston, Chairman of the Tuberculosis Committee, had written a letter to Mr. Chauncey H. Browning, Jr., Commissioner of the Department of Institutions, in which he proposed that a committee be appointed "to study the trends in the care of the tuberculous ill in the state and in our sanatoria, and to make recommendations regarding future care of these patients."

Doctor Nestmann also recommended as members of the committee representatives of the State Medical Association, West Virginia Tuberculosis and Health Association, State Department of Health, and the West Virginia University School of Medicine.

The Executive Secretary stated that Doctor Nestmann had informed him that he had not received an answer from Commissioner Browning as of November 2.

West Virginia Academy of Science

The Executive Secretary reported receipt of a letter from J. F. Bartlett, Dean of the College of Arts and Sciences at Marshall University, in which he discussed the possibility of a relationship or liaison between the West Virginia Academy of Science and the West Virginia State Medical Association.

Following discussion, the Chairman appointed Drs. A. C. Esposito and I. Ewen Taylor as members of a committee to confer with Dean Bartlett for the purpose of discussing the proposal.

The following is a list of those who attended the meeting: Dr. D. E. Greeneltch of Wheeling, Chairman; Dr. L. J. Pace of Princeton, President; Dr. Charles L. Goodhand of Parkersburg, President-Elect; Dr. A. C. Esposito of Huntington, Vice President; Dr. John W. Hash of Charleston, Councillor-at-Large; and Drs. Richard E. Flood, Weirton; Charles L. Leonard, Elkins; Richard V. Lynch of Clarksburg; I. Ewen Taylor of Huntington; Ward Wylie of Mullens; Harold Van Hoose of Man; Richard W. Corbitt, Parkersburg; William B. Rossman, Charleston; Clyde A. Smith, Beckley; and Mr. William H. Lively, Secretary ex officio and Mr. Jerry Gould, Executive Assistant, both of Charleston.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Charles A. Hoffman of Huntington, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. James S. Klumpp of Huntington, Parliamentarian; Mr. William E. Mohler, Attorney for the Association; and Dr. George R. Callender, Jr., Charleston, Chairman of the Joint Conference Committee.

Medical Self-Help Training Program Lagging In West Virginia

State Director of Health N. H. Dyer has urged West Virginians to strive for greater participation in the Medical Self-Help Training Program which was launched last spring.

Writing in the Health Department's weekly "State of the State's Health," Doctor Dyer noted that the State is lagging in achieving the goal of training one person in each family in the skills needed to preserve life and health in an emergency. Medical Self-Help is a national effort developed by the Public Health Service and the Office of Civil Defense, in cooperation with the American Medical Association.

Far Below Goal

The Office of Health Mobilization has received requests for training kits in only 26 counties and fewer than 1,100 persons—out of a goal of 450,000—have enrolled. Doctor Dyer called on local health departments to stress and implement Medical Self-Help in their areas and commented that "class organization has not reached maximum potential in counties where kits have been distributed."

"The twelve lessons require about 16 hours of classroom work and the training is designed to help the novice become a teacher, who, in turn, can provide instruction for others."

He said that the first three lessons—radioactive fallout and shelter; hygiene, sanitation, and vermin control; and water and food—provide "absolutely vital information for survival." Other subjects covered are artificial respiration, bleeding and bandaging, fractures and splinting, burns and shock, transportation of the injured, nursing care of the sick and injured, infant and child care and emergency childbirth.

"One person in each family must learn the art of self-preservation and self-reliance until the services of a physician can be obtained," he asserted. Plans are now being made to provide instruction for members of the Department staff and it is hoped that this training will be offered to other state employees in the future.

Polio, Typhoid Down

Doctor Dyer commented on West Virginia's health progress. "One of the most encouraging notes is the decrease in poliomyelitis while typhoid has dropped approximately 50 per cent from last year," he said. "And as far as deaths are concerned, we can certainly say that the contagious diseases are under control."

He also pointed to "less dramatic victories" and compared the nine deaths from measles last year to the total of 63 twenty years ago. Whooping cough claimed no fatalities last year, but in 1942 there were 52 deaths from this disease.

Committee on Athletic Injuries Established by Council

Dr. Richard W. Corbitt of Parkersburg has been named Chairman of the Committee on Athletic Injuries, a newly-established special committee appointed by the President and approved by the Council at the fall meeting in Charleston on November 4.

Richard W. Corbitt, M. D.

In addition to Doctor Corbitt, the following physicians were named as members of the committee by the President, Dr. L. J. Pace of Princeton:

Drs. Robert L. Chamberlain, Buckhannon; George F. Fordham, Mullens; William E. Gilmore, Parkersburg; Henry R. Glass, Jr., Charleston; J. W. Hesen, Jr., Morgantown; George Naymick, Weirton; W. H. Rardin, Beckley; George W. Rose, Clarksburg; and Harlan A. Stiles, Huntington.

Doctor Corbitt explained that the responsibilities of the Committee will include a study of athletic injuries in the high schools of West Virginia. He said the study also will include the universities and colleges.

He stated that the activities of the Committee will include the following:

(1) A review of the insurance program covering athletes in high schools throughout the State.

(2) A study to determine the type and number of athletic injuries in the State, this material to be compiled and presented by members of the committee in different areas of the State.

(3) A study of the equipment used in different schools, including cost, effectiveness, etc.

(4) A series of conferences on athletic injuries throughout the State, with emphasis on one that will be held in conjunction with the Annual Meeting of the West Virginia Coaches Association in 1963.

(5) Conferences with the Officers of the West Virginia Secondary Schools Activities Commission and officials named for the various athletic events during the year.

It also was suggested that an advisory committee be named consisting of representatives of the high school, university and college coaches and trainers and the West Virginia Secondary Schools Activities Commission.

Meeting of Rheumatism Association

The Ninth Interim Scientific Session of the American Rheumatism Association will be held at the John Marshall Hotel in Richmond, Virginia, December 7-8.

Further information concerning the meeting may be obtained by writing the American Rheumatism Association, 10 Columbus Circle, New York 19, New York.

New Association Members

Dr. Virgil J. Dorset, DuPont Plant, Belle (Kanawha). Doctor Dorset, a native of Washington, D. C., was graduated from George Washington University and received his M. D. degree in 1934 from the George Washington University School of Medicine. He interned at Emergency Hospital, 1934-35, and served a residency in internal medicine at the United States Marine Hospital in Baltimore, 1946-48. He served as a Major in the Medical Corps of the United States Army, 1941-45, and was a Commissioned Officer in the United States Public Health Service, 1935-62. He retired from the service at the Medical Director grade on February 1, 1962.

* * * *

Dr. Wallace W. Duncan, 812 Spring Garden Drive, Bluefield (Mercer). Doctor Duncan was born in Anderson County, Kansas, and was graduated from Southwestern University. He received his M. D. degree in 1953 from Johns Hopkins University School of Medicine and served an internship at the University of Illinois Hospital, 1953-54. He served residencies at the University of Wisconsin, Grace-New Haven Hospital, and Allentown (Pa.) Hospital. He served as a Captain in the Medical Corps of the United States Army, 1955-57, and his specialty is general surgery.

* * * *

Dr. Robert A. Mattill, 1216 Sixth Avenue, Huntington (Cabell). Doctor Mattill, a native of St. Joseph, Missouri, was graduated from North Central College and received his M. D. degree in 1957 from the Northwestern University School of Medicine. He interned at Chicago Wesley Memorial Hospital, 1957-58, and served a residency at Hamot Hospital in Erie, Pennsylvania, 1959-62. He served with the United States Army, 1946-49, and his specialty is orthopedic surgery.

* * * *

Dr. Clarence F. Morrison, Third Street, Sutton (Central West Virginia). Doctor Morrison, a native of Sutton, was graduated from West Virginia Wesleyan College. He attended the two-year School of Medicine at West Virginia University and received his M.D. degree in 1931 from the University of Maryland School of Medicine. He served his internship at the U. S. Naval Hospital in Washington, D. C., 1931-32 and had postgraduate training at the Harvard School of Public Health. He served for 30 years with the Medical Corps of the United States Navy and was released with the rank of Captain.

* * * *

Dr. Robert G. Smith, 1032 Sixth Avenue, Huntington (Cabell). Doctor Smith was born in Huntington and was graduated from Ohio State University. He received his M. D. degree in 1954 from the Ohio State University College of Medicine and served his internship at St. Mary's Hospital in Huntington, 1954-55. He had residency training at the Bowman-Gray School of Medicine and was previously located in Chesapeake, Ohio. His specialty is orthopedic surgery.

Dr. Hugh H. Hussey New Director Of AMA Scientific Division

Dr. Hugh H. Hussey, dean of the Georgetown University School of Medicine in Washington, D. C., and chairman of the American Medical Association's Board of Trustees, has been appointed director of the AMA Division of Scientific Activities.

Dr. F. J. L. Blasingame, executive vice president of the AMA, said Doctor Hussey would assume his new duties at such time as he can be relieved of his responsibilities as dean.

Extensive Program

In his new position, Doctor Hussey will administer programs of seven departments with more than 130 employees and an annual budget of more than $2 million. These departments include Foods and Nutrition, Drugs, Medical Physics and Rehabilitation, Medical Education and Hospitals, Nursing, Scientific Assembly and Advertising Evaluation.

Doctor Hussey, 52, is a native of Washington, D. C., and received his M. D. degree from the Georgetown School of Medicine in 1934. He served an internship at the Georgetown University Hospital and a year as a Fellow in Medicine at the University. He entered private practice in 1936 and that same year joined the Georgetown faculty, an affiliation which has continued without interruption.

Named Dean in 1958

He became a full-time Associate Professor of Medicine in 1950 and was appointed Professor and Chairman of the Department of Preventive Medicine in 1953. Three years later, he was named Chairman of the Department of Medicine and Dean of the School of Medicine in 1958.

Doctor Hussey has long been active in organized medicine. He was elected to the AMA House of Delegates in 1950 and to the Board of Trustees in 1956. He served as vice chairman of the Board in 1960-61, and was elected chairman in June, 1961.

Officers, Board Members Elected By W. Va. Nurses Association

Sister Mary Helen, Assistant Director of the School of Nursing at St. Mary's Hospital in Huntington, was elected first vice president of the West Virginia Nurses Association during the annual meeting in Huntington, October 17-19.

The following registered professional nurses were also elected to two-year terms during the meeting:

Mrs. Ardenia Tulley of South Charleston, secretary, and Miss Charleen Lindsay of Clarksburg and Miss Audrey Windemuth of Morgantown, to the Board of Directors.

Miss Mary M. Lemons of Beckley, president, Mrs. Josephine Fultz of Clarksburg, second vice president, and Mrs. Mabel Strong of Glen Dale, were elected in 1961 for two-year terms.

More Than 100 Attend 10th Annual Bluefield Sanitarium Seminar

More than 100 persons attended the 10th Annual Medical Seminar, sponsored by the Bluefield Sanitarium, the Stevens Clinic and the Clinch Valley Clinic, which was held at the Bluefield Country Club in Bluefield on October 25.

Dr. Harry J. Warthen, Jr., of Richmond, Virginia, was the speaker at the banquet. His subject was "Why Did Stonewall Jackson Die?" A scientific session was held in the afternoon and a social hour preceded the banquet.

These physicians participated in the 10th Annual Medical Seminar held in Bluefield on October 25. Seated, left to right, are Drs. Fred K. Garvey of Winston-Salem, North Carolina, Harry J. Warthen, Jr., Richmond, Virginia, and Angus E. McBryde, Durham, North Carolina. Standing: Drs. Fred D. White, Wade H. St. Clair, Jr., and Henry F. Warden, Jr., all of Bluefield.

Doctor Warthen, Associate Professor of Surgery at the Medical College of Virginia and Editor of the *Virginia Medical Monthly*, said that Jackson's wounds would have been only "minor injuries" in World War II.

A noted authority on the Civil War, Doctor Warthen pointed out that Jackson was wounded only in the arm and hand, but his attending physician removed his arm and the Confederate General developed post-operative pneumonia which took his life. In his discussion, he compared medical practice of the Civil War era and today, showing the tremendous advancements which have been made.

Dr. Angus E. McBryde of Durham, North Carolina, was the opening speaker in the scientific session. He presented a paper on "The Challenge of Prematurity." Doctor McBryde is Professor of Pediatrics at the Duke University School of Medicine.

Dr. Fred K. Garvey, Professor of Urology at Bowman-Gray School of Medicine, Winston-Salem, North Carolina, delivered a paper on "Urologic Problems in Pediatric Practice."

Dr. Henry F. Warden, Jr., of Bluefield, served as Chairman of the Program Committee for the Seminar.

Dr. E. J. Van Liere Reelected To Publication Committee

Dr. E. J. Van Liere of Morgantown, Dean Emeritus of the West Virginia University School of Medicine, has been reelected by the Council as a member of the Publication Committee of the West Virginia State Medical Association for the term ending December 31, 1969.

E. J. Van Liere, M. D.

The Publication Committee is composed of a chairman, who is the Editor of *The West Virginia Medical Journal*, and six other members who serve as associate editors. The Committee is in charge of the publication of *The Journal*, which is the official organ of the West Virginia State Medical Association.

Doctor Van Liere is a native of Kenosha, Wisconsin, and a graduate of the University of Wisconsin where he received a Bachelor of Science degree in 1915 and Master of Arts in 1916. He received his M. D. degree from the Harvard Medical School in 1920, and a Ph. D. degree in physiology from the University of Chicago in 1927.

He served for the school year 1920-21 as Professor of Physiology at the University of South Dakota School of Medicine before joining the WVU School of Medicine faculty in the fall of 1921 as Professor and Chairman of the Department of Physiology.

In 1935, Doctor Van Liere was named Dean of the School of Medicine, a position he held until his retirement in 1960. He continues, however, to serve as Professor of Physiology at the WVU School of Medicine.

W. B. Saunders Company to Award $15,000 Writing Grant

The W. B. Saunders Company, medical and scientific publishers, will award a $15,000 writing fellowship grant to mark its 75th Anniversary in 1963.

The purpose of the grant is to provide for a year's leave of absence for an investigator who has been doing fruitful and significantly important biomedical laboratory research over the past several years and would now like to prepare his work in monographic form. The recipient will not have to agree to publish his monograph with the Saunders Company and will be free to write, instead of a book, a series of journal articles reviewing his research.

Further information may be obtained by writing to Dr. Robert F. Loeb, W. B. Saunders Company, West Washington Square, Philadelphia 5, Pennsylvania.

Two Physicians Will Serve in 56th West Virginia Legislature

Two physicians will serve in the first session of the 56th West Virginia Legislature which will be convened in Charleston on Wednesday, January 9.

Dr. Ward Wylie of Mullens, a member of the Council, represents the 9th District in the State Senate. He has been a member of that body since 1938 with the exception of a tour of duty with the Medical Corps of the United States Army during World War II. Doctor Wylie was named President Pro Tempore of the Senate in the 53rd, 54th and 55th Legislatures.

Dr. T. G. Matney of Peterstown was elected to his fifth term in the House of Delegates from Monroe County in the general election on November 6.

Several bills of interest to the medical profession will be introduced during the 60-day session. The headquarters offices of the State Medical Association in Charleston will prepare and mail Legislative Bulletins to the entire membership during the session. News of legislative proceedings will also be carried in future issues of *The Journal*.

Dr. R. J. Johnson Reelected Head Of W. Va. Cancer Society

Dr. Robert J. Johnson of Morgantown was reelected president of the West Virginia Division of the American Cancer Society during the recent annual meeting of that organization which was held in Wheeling.

Doctor Johnson is Professor and Chairman of Gross and Neurological Anatomy at the West Virginia University School of Medicine.

Dr. John C. Condry of Charleston was named vice president and Mr. George Darden, Jr., of Elkins, secretary. Mr. Max W. Saunders of Charleston was reelected treasurer.

Eleven new members were named to the board of directors as follows: Mrs. W. W. Barron, William T. Brotherton, Jr., Dr. Frederick T. Edmunds and Chapman Revercomb, all of Charleston; William B. Swope of Welch; Dr. Jack R. Price, Williamson; Drs. James P. Carey and Banks Wilburn, Huntington; Mrs. Julian Stanley, St. Marys; Dr. Clarence F. Morrison, Sutton; and Dr. L. Walter Fix of Martinsburg.

ACP Course in New York City

A Postgraduate Course on "Diseases of the Blood Vessels and Problems of Thromboembolism—Diagnosis and Treatment," will be sponsored by the American College of Physicians in New York City, January 21-25.

Dr. Irving S. Wright will serve as director of the course which is designed to present a review of recent advances in the treatment of vascular thromboembolic diseases. Registration will be limited to 100 physicians.

Further information may be obtained by writing the American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania.

Essay Contest for Students

Three cash awards totaling $1,000 will be given by the Council on Undergraduate Medical Education of the American College of Chest Physicians for the best essays by undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases.

The first prize will be $500; second prize $300; and third prize $200. A committee of chest specialists will select the winning papers which will be announced at the Annual Meeting of the ACCP in Atlantic City, June 13-17, 1963.

Further information may be obtained by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Medical Meetings, 1963

The following is a partial list of national, state and district medical meetings scheduled for 1963:

Apr. 17-20—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
May 3-4—W. Va. Soc. Med. Technologists, Clarksburg.
May 24-26—W. Va. Chapter AAGP, Charleston.
June 16-20—AMA Annual Meeting, Atlantic City.
Aug. 22-24—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Oct. 9-11—W. Va. Hospital Association, Wheeling.
Oct. 10-12—AMA School Conference, Chicago.
Oct. 27-31—ACS Clinical Congress, San Francisco.
Dec. 1-4—AMA Clinical Meeting, Portland, Ore.

Relocations

Dr. Marvin Kirsh, who practiced medicine in Montgomery for the past four years, has relocated his practice in Cincinnati and his office address is 682 Danbury Road.

* * * *

Dr. Raymond W. Sass, formerly of Elkins, has moved to Espanola, New Mexico, where he is engaged in the practice of his specialty of obstetrics and gynecology. His address is Box 389.

Dr. Thomas H. McGavack President Of W. Va. Diabetes Association

Dr. Thomas H. McGavack of Martinsburg was elected president of the West Virginia Diabetes Association during the annual meeting which was held at the West Virginia University Medical Center in Morgantown on September 22.

Thomas H. McGavack, M. D.

Other officers were elected as follows:

Dr. Richard V. Lynch, Jr., of Clarksburg, president-elect; Dr. Lyle D. Vincent of Parkersburg, vice president; and Dr. Leo H. T. Bernstein of Martinsburg, secretary-treasurer.

Named to the board of directors were Drs. A. C. Thompson of Elkins; Oliver H. Brundage and John H. Gile of Parkersburg; Paul P. Warden of Grafton; William A. Thornhill, Jr., and George P. Heffner of Charleston; Halvard Wanger of Shepherdstown; F. R. Whittlesey of Morgantown; and Delmar J. Brown of Parkersburg.

Drs. John Jones and John Nelson, members of the WVU School of Medicine faculty, presented a paper on "Diabetic Myelopathy" during the scientific session. Papers also were presented by Dr. Thaddeus Danowski of the University of Pittsburgh School of Medicine, and Dr. William G. Gwinup of the Ohio State University College of Medicine.

Heavy cigarette smokers experience a threefold increase in the incidence of myocardial infarction and in death from all causes as compared to nonsmokers, pipe and cigar smokers and former cigarette smokers. —New England Journal of Medicine.

The 1962 Fall Conference and Board of Directors' meeting of the Woman's Auxiliary to the West Virginia State Medical Association was held at Oglebay Park in Wheeling, October 10-11. Mrs. Howard G. Weiler of Wheeling, right, the president, presided at the business meeting. Also attending the meeting were, left to right, Mrs. C. J. Holley of Wheeling, corresponding secretary; Mrs. J. E. Spargo, Jr., of Wheeling, parliamentarian; Mrs. Grover C. Hedrick, Jr., of Beckley, treasurer; and Mrs. Pat A. Tuckwiller of Charleston, president elect.

USPHS To Undertake Study of Chest Diseases in Soft Coal Miners

The Division of Occupational Health, U. S. Public Health Service, is undertaking a comprehensive study of chronic chest diseases in soft coal miners. Emphasis will focus primarily on coal pneumoconiosis, a progressive disease that frequently results in a disabling massive fibrosis of the lungs. Although this disease is considered by many authorities as an outstanding occupational disease problem in the United States at present, very little research is being directed to it, except for four research projects supported by Public Health Service grants.

The study will seek to determine the extent to which chronic pulmonary disease is a problem among coal workers, its underlying causes, the course of the disease, and its social impact. Information developed will assist in the prevention, diagnosis and treatment of the disease. The project consists of three parts: (1) a prevalence survey, (2) pathologic and etiologic studies, and (3) environmental studies.

A field team, using mobile equipment, will study carefully selected population samples to determine the amount and character of pulmonary disease in active and retired coal miners in Southern West Virginia. The medical study will include a standard 14" x 17" chest x-ray, a thorough clinical and occupational history, and standardized pulmonary function tests. Sputum samples will be collected for an initial period to determine the usefulness of cytologic examinations. This study is expected to begin about January 1, 1963.

Field studies of cardio-pulmonary function will be supported by laboratory studies by the Division of Occupational Health, as well as special studies to be performed under contract. The Division is developing contracts with the Beckley Memorial Hospital and other hospitals in the coal mining area to collect specified data on miners regardless of the reason for hospitalization, including pathologic studies of the lungs of deceased miners.

Preliminary studies of work capacity will also be carried out, using a battery of ergonomic tests to characterize the work capacity of miners with various degrees of lung involvement.

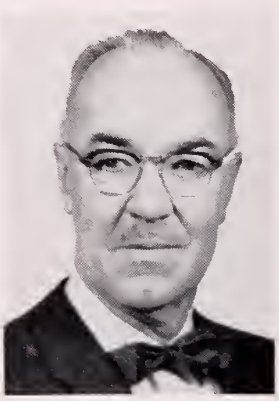
Studies of the mine environment, including the amount and nature of respirable dust and other factors possibly affecting the lungs, will not get under way until 1964. At present, pilot environmental studies are being planned in cooperation with the U. S. Bureau of Mines, using the experimental mine of the Bureau to test dust evaluation techniques.

Medical information will be released to the patient's physician when, in the judgment of the Public Health Service physicians, withholding it might lead to impairment of health. Examples of impairments to be reported include suspected tumors, suspected active tuberculosis, and evidence of cardiac disease. Suspected pneumoconiosis will not be so reported unless the subject requires prompt medical attention. Medical records and x-ray films will remain the property of the Public Health Service and be kept in confidence.

A report on the study will be issued by the Public Health Service only when sufficient information has been collected to permit drawing valid conclusions. Such a report will be a public document and copies will be sent to all interested groups and associations.

Dr. John J. Lawless New President Of TB and Health Association

Dr. John J. Lawless of Morgantown was elected president of the West Virginia Tuberculosis and Health Association during the 42nd annual meeting which was held in Beckley, October 9-11. Other new officers for the coming year are as follows:



John J. Lawless, M. D.

Mr. E. R. Phelps of Bluefield, vice president; Miss Lela House of Williamstown, secretary; and the Rev. Winton R. Houck of Charleston, treasurer.

Hupp E. Otto of Wheeling, the immediate past president, was among five new members named to the Executive Committee. The others were Oscar J. Andre of Clarksburg; Dr. William L. Cooke of Charleston; Dr. Lewis N. Fox of Beckley; and Mrs. H. J. Hindman of Morgantown.

Dr. Richard V. Lynch, Jr., of Clarksburg, was reelected president of the West Virginia Thoracic Society, which held its annual meeting on October 10. Also reelected were Drs. Preston C. Davis of Beckley, vice president, and Morris H. O'Dell of Charleston, secretary-treasurer.

A postgraduate course on "Current Concepts of Pulmonary Diseases" was held on October 9 with Dr. Charles E. Andrews of Morgantown presiding. The course was sponsored jointly by the West Virginia University School of Medicine, the Tuberculosis and Health Association and the Thoracic Society.

PG Course in Ophthalmology

A postgraduate course on "Newer Developments in Ophthalmology" will be presented at the Cleveland Clinic Educational Foundation in Cleveland, December 5-6. The foundation formerly was known as the Frank E. Bunts Educational Institute.

The course will be presented by staff members of the Cleveland Clinic Foundation, assisted by several guests speakers. The registration fee is $30 and registrations will be limited to 125 persons.

Further information may be obtained by writing Dr. Walter J. Zeiter, Director of Education, The Cleveland Clinic Educational Foundation, 2020 E. 93rd Street, Cleveland, Ohio.

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1. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, The Williams & Wilkins Company, 1955, p. 578.

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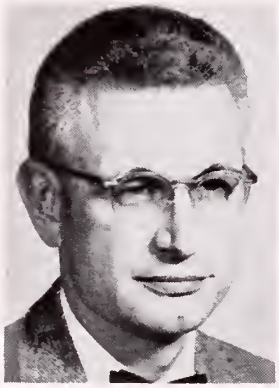
Research in the Service of Medicine

WVU Medical Center
—News—

DR. Bernard Zimmermann, Professor and Chairman of the Department of Surgery at the West Virginia University School of Medicine, has received an $18,000 grant for cancer research. Approval of the grant was announced at the annual meeting of the West Virginia Division of the American Cancer Society at Wheeling in October. Drs. Cornelia Hoch-Ligeti and Emil R. Swepston of the Martinsburg VA Center also received $10,000 and $1,550 cancer research grants.



Bernard Zimmermann, M. D.

Dr. Zimmermann formerly served as a professor in the Department of Surgery at the University of Minnesota School of Medicine before joining the WVU faculty on July 1, 1960. He has been active in the field of cancer research and surgery and is the author of many surgical papers and monographs.

A native of St. Paul, Minnesota, Doctor Zimmermann is a graduate of Harvard and received his M. D. degree from Harvard Medical School in 1945. He received a Ph. D. degree in surgery at the University of Minnesota in 1953 and immediately became an assistant professor at its School of Medicine.

Census Shows 33 Per Cent Increase

A census of students, faculty and staff at the WVU Medical Center on October 1 totalled 1,708, a 33 per cent increase over the 1,289 on the same date in 1961.

The figures on student growth were as follows:

Medical students, 206 compared to 160 last year; dental, 114-105; nursing, 125-94; pharmacy 67-62; graduate students 68-40; dental hygiene, 10-2; and medical technology, 25-18. Of the 642 students, 518 are West Virginia residents and 124 from out-of-state and foreign countries.

Kanawha County leads with 71 students at the Medical Center followed by Monongalia with 59, Marion 37, Harrison 36, Cabell 28, and Ohio 23. Fifty-two of West Virginia's 55 counties are represented.

The basic sciences and clinical staffs show 175 persons, an increase of 34 over the 1961 total. This includes professors, associate professors, instructors and others who are teaching and doing research in all fields of health sciences. Service personnel has grown from 640 in 1961 to 849 this year.

• **Compiled from material furnished by Howard Lewis, Administrative Assistant to the Vice President, West Virginia University Medical Center, Morgantown, West Virginia.**

New Member of Faculty

Dr. Orlando L. Fernandez of Clarksburg has been appointed an Assistant Professor of Medicine at the WVU School of Medicine.

A native of Cuba and a member of the staff at the Clarksburg VA Hospital, Doctor Fernandez received his M. D. degree from the University of Havana School of Medicine and served his internship at the University Hospital.

He holds memberships in the Cuban Society of Cardiology, the Havana Society of Internal Medicine and the Cuban Society of Angiology.

Health Sciences Reporting Symposium

Representatives from the news media in West Virginia, Maryland and Pennsylvania attended a Symposium on Health Science Reporting at the WVU Medical Center, November 9-10.

The two-day program was sponsored by the Medical Center and the West Virginia University School of Journalism and financed through a grant from the National Science Foundation. Its purpose was to develop an awareness of opportunities and responsibilities in reporting in the health sciences field and ultimately to provide better science coverage for the readers, listeners and viewers.

Speakers included Earl Ubell of New York City, Science Editor of the New York Herald-Tribune, John Troan of Washington, D. C., science writer for the Scripps-Howard Newspaper Alliance, and Miss Jane Stafford of the National Institutes of Health in Bethesda, Maryland.

Dr. Bernard Zimmermann, Professor and Chairman of Surgery at the WVU School of Medicine, served as a member of two panels and Dr. Margaret J. Albrink, Associate Professor of Medicine, presented a paper on her research into the relationship of triglycerides with heart disease.

Doctor Albrink oriented the conferees on what might be done to close the "communication lag" between the scientist and the lay public, pointing out possible points of news interest and also pitfalls in science reporting. She is an established investigator of the American Heart Association and one of the few persons in the United States working on research of triglycerides, a type of blood fat.

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William D. Keck, M. D.
Edward W. Gamble, III, M. D.
J. William Giesen, M. D.
Internist (Consultant)

Don Phillips
Administrator

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David M. Wayne, M. D.
Phone:325-9159

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va.
W. E. Wilkinson, M. D.
Malcolm G. MacAulay, M. D.
Phone: 253-8397

Charleston Mental Health Center
1119 Virginia St., E., Charleston, W. Va.
Phone: 344-3578

Norton Mental Health Clinic
Norton Community Hospital, Norton, Va.
Pierce D. Nelson, M. D.
Phone: 218, Ext. 55 and 56

The Month in Washington

• From the Washington Office of the American Medical Association.

A Public Health Service study of possible links between cigarette smoking and lung cancer got underway with appointment of a 10-member advisory committee including eight physicians from the academic field. Dr. Luther L. Terry, Surgeon General of the PHS and chairman of the committee, said he selected the 10 members on the basis of geographic distribution and balance among professional disciplines, scientific objectivity, competence in special fields of interest, ability to think broadly outside of one particular field of interest, and ability to critically analyze a point of view.

In addition to being a committee member, Dr. Stanhope Bayne-Jones also is serving as a special consultant to the committee staff. He is a former dean of the Yale School of Medicine and a former president of the American Society of Pathology and Bacteriology.

"This committee is not merely an aggregate of ten men," the Surgeon General said. "It is a composition of specialists covering the broad range of medical sciences involved in evaluating the complex relationship between tobacco smoking and health. I expect the committee to be a dynamic, productive and creative group that will shed light on these complex questions."

The committee members were selected from a list of approximately 150 names submitted by Federal agencies, voluntary health organizations and the tobacco industry.

Comprehensive Review

In the first phase of its activity, the committee is making a comprehensive review of all available data on smoking and other factors in the environment that may affect health. It is expected that this review will be completed by next summer.

The second phase of the study will concern recommendations for action. No decision on how the second phase is to be conducted will be made until the first phase has been completed.

Soon after appointment of the committee, the National Cancer Institute under PHS issued a new booklet "Cancer Cause and Prevention" which referred to the conclusion reached by the PHS in 1959 that smoking is the principal reason for the steep rise in lung cancer cases.

The booklet discusses cancer as a preventable disease. It describes environmental and personal factors involved in the causation of cancer, and occupational cancer hazards that to some extent may be avoided. It goes into the problems of air pollution, radiation exposure, and food additives.

The booklet points out that as the older age group in the population increases, more people are living long enough to develop cancer induced by exposure to a causative agent earlier in life. Such cancers may take as long as 40 years to appear, it says.

"Thus," the publication concludes, "mortality from malignant disease in the future can be reduced by continuous identification and eradication of cancer hazards."

FDA Receives Criticism

The Food and Drug Administration was criticized as to both policies and operation by a Citizens Advisory Committee and some members of Congress.

A special advisory committee—appointed by the Secretary of Health, Education and Welfare and headed by Dr. George Y. Harvey, a political science lecturer at the University of Missouri—said the FDA had fallen short in carrying out its responsibility of protecting the American public against unsafe drugs, therapeutic devices and foods.

The FDA came in for even sharper criticism from Sen. Hubert H. Humphreys (D., Minn.) who indicated his Senate Government Operations Sub-committee would hold hearings in December on the agency. He charged the FDA lacks the ability and competence to carry out the new drug law effectively.

He accused the agency of failure to keep in touch with other government health projects and outside experts.

"Drugs have been approved which FDA now admits should never have been approved," Humphrey said. "Drugs have been kept on the market long after FDA admits they should have been eliminated from the market."

The 16 doctors, educators, businessmen and consumers on the advisory committee reported to HEW Secretary Anthony J. Celebrezze after a year-long study of FDA programs and procedures.

Making 10 major recommendations for overhauling FDA's approach to consumer protection, the panel said the federal agency had been relying on "after-the-fact enforcement" of regulations rather than taking more preventive action.

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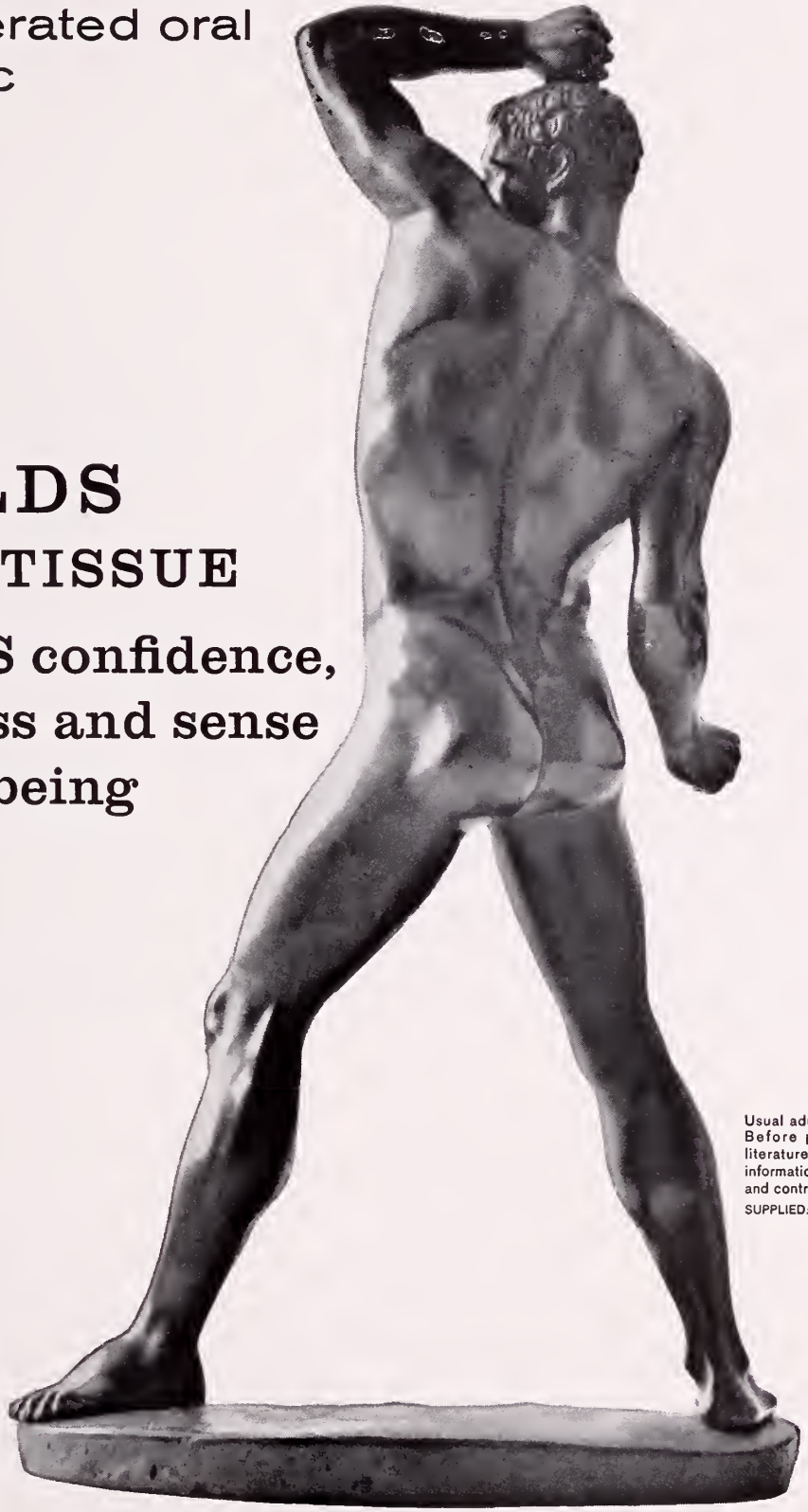

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Obituaries

HENRY DRURY HATFIELD, M. D.

Dr. Henry Drury Hatfield, 87, of Huntington, the 14th Governor of West Virginia and a former United States Senator, died on October 23 at his home in that city.

Doctor Hatfield, who achieved national prominence in both medicine and politics, was a native of Logan County. He was born September 15, 1875, the son of the late Elias and Elizabeth Chafin Hatfield.

He served as Governor from 1913 to 1917 and in the United States Senate from 1929 through 1934. During his term as Governor, Doctor Hatfield succeeded in obtaining passage of a Workmen's Compensation Act which became a model for similar legislation in many other states.

The State Department of Health, State Hygienic Laboratory, Public Service Commission and a Labor Bureau also were established during the administration of Doctor Hatfield.

Doctor Hatfield, who was a nephew of "Devil Anse" Hatfield of the Hatfield-McCoy feud fame, was licensed to practice in West Virginia in 1893 following his graduation from the University of Louisville School of Medicine.

Doctor Hatfield had postgraduate work at the New York Polyclinic, New York University College of Medicine and Rush Medical College in Chicago.

He opened his practice at Eckman in McDowell County and he entered public life with his appointment as Mingo County Health Commissioner in 1895. He served briefly as a member of the McDowell County Court before his election to the West Virginia State Senate in 1908.

Doctor Hatfield was made president of the State Senate in 1911 and the following year defeated William R. Thompson of Cabell County by a plurality of 8,770 votes in the gubernatorial race.

When he left the Governor's office in 1917, Doctor Hatfield entered the Medical Corps of the United States Army as a Captain. He was chief surgeon at an Army Hospital in Detroit and was released with the rank of Lieutenant Colonel.

Doctor Hatfield, who aided in the establishment of the State Miners Hospital at Welch, resumed his practice in Huntington following World War I and established a hospital in that city and another in Logan.

In 1928, he defeated the late M. M. Neely of Fairmont for election to the U. S. Senate before losing to the late Rush D. Holt six years later. An ardent Republican, Doctor Hatfield took an active interest in party affairs throughout most of his life and during his Senate term was a confidant of former President Herbert Hoover.

Doctor Hatfield was an honorary life member of the Cabell County Medical Society, West Virginia State Medical Association and the American Medical Association.

His only survivor is a daughter, Mrs. Benjamin F. Fairless of Palm Springs, California.

* * * *

HOUSTON G. FOSTER, M. D.

Dr. Houston G. Foster, 60, of Cambridge, Maryland, died on October 18 in that city.

Doctor Foster served as a staff psychiatrist at Weston State Hospital for five years before assuming a similar position at the Eastern Shore State Hospital near Cambridge in 1961.

He was a native of Port Townsend, Washington, and attended Dickinson College at Carlisle, Pennsylvania. He received his M. D. degree in 1927 from the University of Pennsylvania School of Medicine.

Doctor Foster interned at the U. S. Marine Hospital in Norfolk, Virginia, 1927-28, and was a member of the staff at the Eastern North Carolina Sanatorium in Wilson, North Carolina, before joining the staff at Weston in October, 1956.

He was a former member of the Central West Virginia Medical Society, the West Virginia State Medical Association and the American Medical Association.

* * * *

WILLIAM FRANK HARLESS, M. D.

Dr. William Frank Harless, M. D., 81, of Madison, died on November 12 at a hospital in that city.

Doctor Harless, who practiced for more than a half-century in the Southern West Virginia coalfields, was a native of Linden, Roane County, where he later taught in the public schools.

He received his M. D. degree from the University of Louisville School of Medicine in 1908 and served an internship at the Louisville City Hospital before opening his practice at Grantsville in 1909.

Doctor Harless moved to Clothier in Logan County in 1910 and remained there for 20 years prior to moving to Madison in 1930 where he served as vice president of Madison General Hospital.

He was a past president of the Boone County Medical Society and an honorary life member of that society, the West Virginia State Medical Association, Southern Medical Association and the American Medical Association.

Besides his widow, he is survived by a daughter, Mrs. Eleanor Harless Haner of Madison.

* * * *

CHARLES SAMUEL MAHAN, M. D.

Dr. Charles Samuel Mahan, 54, of Morgantown, died of a heart ailment on November 5 at the West Virginia University Hospital.

Doctor Mahan was born in Follansbee, April 4, 1908, the son of the late John S. and Mary Richey Mahan. He was graduated from Washington & Jefferson College and received his M. D. degree from the University of Pennsylvania School of Medicine in 1935.

He opened his practice in Mt. Morris, Pennsylvania, in 1936 and came to Morgantown three years later.

Doctor Mahan was a member of the Monongalia County Medical Society, the West Virginia State Medi-

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cal Association, the American College of Obstetrics and Gynecology and the American Medical Association.

Besides his wife, he is survived by two sons, Charles S. Mahan, a medical student at Northwestern University, and David C. Mahan of Morgantown, and one brother, Byron R. Mahan of Corpus Christi, Texas.

* * * *

JAMES ARTHUR NEWCOME, M. D.

Dr. James Arthur Newcome, 65, of Columbia, South Carolina, died on October 17 at his home in that city.

Doctor Newcome practiced for a number of years in Keyser before joining the Veterans Administration at Roanoke, Virginia, in 1947.

He received his M. D. degree from the University of Virginia School of Medicine in 1925 and was licensed to practice in West Virginia that same year. During World War II he served in the Medical Corps of the United States Army.

Doctor Newcome was a past president of the Potomac Valley Medical Society, and was a former member of the West Virginia State Medical Association and the American Medical Association.

Besides his wife, he is survived by two sons, Hal R. Newcome of Columbia, South Carolina, and James A. Newcome, II, of Pensacola, Florida; and one brother, John Newcome of Pensacola.

* * * *

CECIL BENJAMIN PRIDE, M. D.

Dr. Cecil Benjamin Pride, 69, of Morgantown, a member of the West Virginia Medical Licensing Board since 1949 and Clinical Professor of Surgery at the West Virginia University School of Medicine, died at his home in that city on November 12.

Doctor Pride was a native of Rockland, Ohio, and graduated from Ohio Wesleyan University in 1916. He taught in public schools at Gallipolis, Ohio, before serving in the United States Navy in World War I.

After his release from the Navy, he attended the two-year School of Medicine at West Virginia University and received his M. D. degree from the Western Reserve University School of Medicine in 1923. He had three years postgraduate work in surgery before opening his practice in Morgantown in 1926. He served for a number of years as a part-time member of the faculty at the two-year WVU School of Medicine and was named Clinical Professor of Surgery upon completion of the four-year curriculum.

Doctor Pride was a past president of the Monongalia County Society and an honorary life member of that Society, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by a step-daughter, Mrs. Mary Carter Winner of Germany; a brother, Eber Pride of Rockland, Ohio; and two nephews, Dr. Maynard P. Pride of Morgantown and Russell Pride of Rockland, Ohio.

* * * *

ROBERT MORRIS WYLIE, M. D.

Dr. Robert Morris Wylie, 79, of Huntington, died on November 2 at a hospital in that city.

Doctor Wylie was born in Trenton, Ohio, on October 23, 1883, son of Robert and Adelia Jadden Wylie. He

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was a graduate of Denison University and received his M. D. degree in 1923 from the Johns Hopkins University School of Medicine.

He practiced in Huntington from 1924 until his retirement three years ago. Doctor Wylie was a former Huntington City Health Officer and a member of the Board of U. S. Civil Service Examiners.

Doctor Wylie was an honorary life member of the Cabell County Medical Society, West Virginia State Medical Association, American College of Physicians, American Board of Medical Examiners and the American Medical Association.

Besides his wife, he is survived by a sister, Mrs. Mabel O. Loughridge of Milledgeville, Georgia.

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In the first six months of 1962, 75 Blue Shield Plans paid for nearly a half billion dollars worth of professional services that were rendered for those of the 50 million Blue Shield members who needed such medical services in that period. At its present rate of growth, Blue Shield will probably pay physicians more than one billion dollars in 1962.

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While the several hundred commercial accident and health insurance companies, in aggregate, cover more people and pay out more money in the course of a year than do the 75 Blue Shield Plans, it is Blue Shield that has set the pace and established benefit patterns and fee schedules at levels that will substantially protect the patient and reasonably compensate his doctor.

What has medicine invested in Blue Shield? For the past 25 years, thousands of dedicated doctors have given lavishly of their time and energy as trustees, directors and committee members in their local Plans. Thousands more supported their efforts by providing services under arrangements which, in the early days, represented a substantial contribution to the Blue Shield program as well as to the welfare of their patients and the freedom of our medical care system.

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County Societies

CABELL

Dr. Jack Leckie of Huntington was elected president of the Cabell County Medical Society at the regular monthly meeting held in the Georgian Terrace Room of the Hotel Frederick in Huntington on October 11. He succeeds Dr. James A. Heckman, also of Huntington.

Other officers, all of Huntington, named to serve during the coming year are as follows:

Dr. Clarence H. Boso, president elect; Dr. Thomas J. Holbrook, vice president; Dr. W. L. Neal, reelected secretary; Dr. Walter R. Wilkinson, treasurer; and Dr. Lawrence B. Gang, Board of Censors.

Thirty members attended the meeting and observed a minute of silence in memory of Dr. Oscar B. Biern of Huntington, who died on October 10. A note of appreciation from the family of Dr. Thomas W. Moore also was read. Doctor Moore, 95, of Huntington, a past president of the West Virginia State Medical Association and the Southern Medical Association, died on August 28.

Dr. Robert G. Smith of Huntington was unanimously elected to membership in the Society and Dr. Charles E. Hamner of Charleston to honorary life membership.—W. L. Neal, M. D., Secretary.

HARRISON

Congressman Arch A. Moore, Jr., of Glen Dale, was the guest speaker at a dinner meeting of the Harrison County Medical Society at the Stonewall Jackson Hotel in Clarksburg on October 23.

In his address, he outlined for an audience of about 200 persons pending federal legislation in the field of medical care. He said that while the recent session of Congress did not handicap the medical profession, there would be those serving in the forthcoming session who would endeavor to take it "down the road to socialized medicine."

Congressman Moore discussed the King-Anderson type legislation which would place medical care for the aged under Social Security, various amendments to that measure, alternate bills, and the Kerr-Mills program which is now in operation in West Virginia and other states.

Dr. Andrew J. Weaver of Clarksburg, the president, presided at the meeting and Dr. Paul E. Gordon of Clarksburg introduced Congressman Moore. Dr. George F. Evans of Clarksburg arranged the program.

The regular monthly meeting of the Harrison County Medical Society was held at the Stonewall Jackson Hotel in Clarksburg on November 1.

Dr. Thomas A. Loftus, Professor and Chairman of the Department of Psychiatry at the West Virginia University School of Medicine, discussed "The Uses of Drugs in the Treatment of Psychiatric Cases."

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KANAWHA

Dr. Charles J. Frankel of Charlottesville, Virginia, was the guest speaker at the regular monthly meeting of the Kanawha Medical Society which was held at the Daniel Boone Hotel in Charleston on October 24.

Doctor Frankel, a member of the faculty at the University of Virginia School of Medicine and also an attorney, discussed forensic medicine at the meeting which was held jointly with the Kanawha County Bar Association.

He told an audience of more than 150 persons that third-party mediation would not resolve the existing differences between the medical and legal professions and suggested that mutual understanding and cooperative agreements "among ourselves" would provide the basis for better understanding.

* * * *

McDOWELL

Dr. C. Merle Bundy of Pittsburgh, Chief Surgeon for the United States Steel Corporation, was the guest speaker at the regular monthly meeting of the McDowell County Medical Society held at Stevens Clinic Hospital in Welch on September 12.

Dr. James H. Anderson of Hemphill also spoke on the support by organized medicine of political candidates who are opposed to King-Anderson type legislation which would place medical care for the aged under Social Security.

Dr. Richard O. Gale also presented a report as chairman of the District Review Committee.—J. Hunter Smith, M. D., Secretary.

* * * *

MERCER

The Mercer County Medical Society held its regular monthly meeting at the West Virginian Hotel in Bluefield on October 18.

Dr. Joseph Marsh of Athens, President of Concord State College, was the guest speaker. He discussed recent advances at the school and its future possibilities.

Doctor Marsh said that while education is the purpose of a liberal arts college, it should also contribute to the welfare of the community.

Dr. Joe E. McCary of Princeton, the president, presided at the business meeting at which time Drs. J. E. Blaydes, Jr., W. E. Copenhaver and J. Brookins Taylor, all of Bluefield, were appointed to a committee for the Christmas Banquet.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. Roger B. Scott of Cleveland was the guest speaker at the regular monthly meeting of the Monongalia County Medical Society in Morgantown on October 2.

Doctor Scott, Associate Professor of Obstetrics and Gynecology at the Western Reserve University School of Medicine, discussed "Hormonal Relationship of External Endometriosis."

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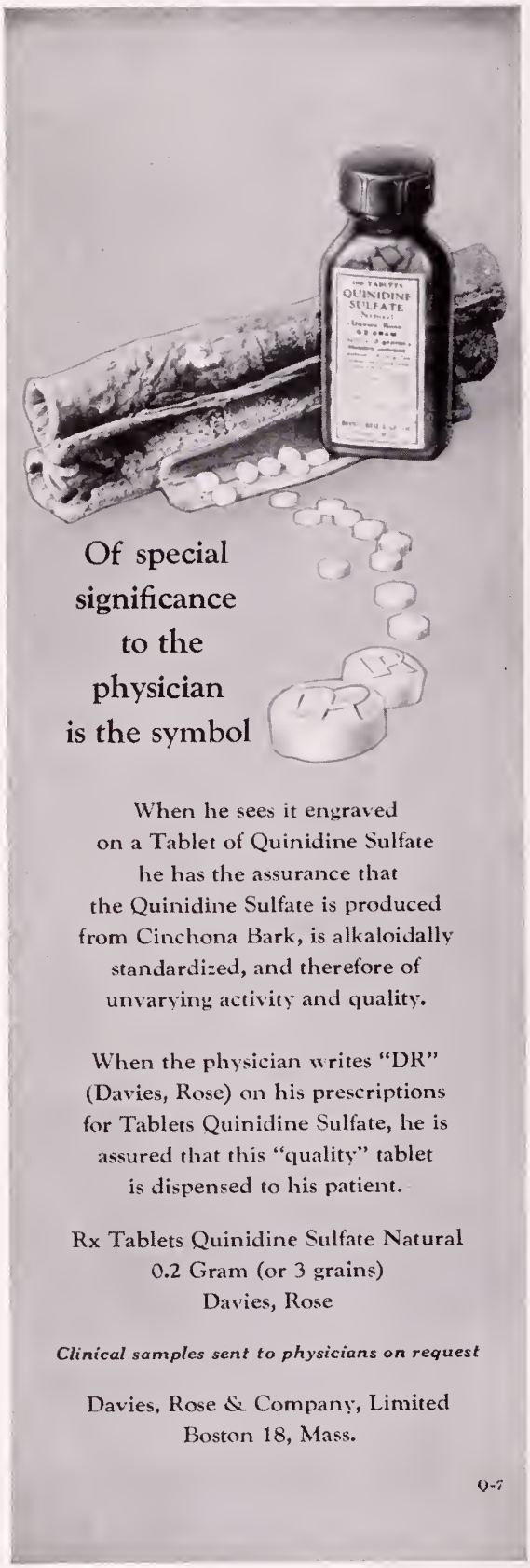

Dr. C. Truman Thompson of Morgantown, the president, presided at the business meeting. Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine, discussed the AMA Education and Research Foundation plan which guarantees bank loans to medical students, interns and residents.

The Society endorsed a plan by Dr. C. C. Mascoli of the Department of Microbiology at the WVU School of Medicine to study and identify influenza viruses in cooperation with the Monongalia County Health Department.

Dr. David Z. Morgan presented a paper on "Unilateral Renal Artery Disease and Hypertension" at the regular monthly meeting held in Morgantown on November 6.

A letter from the Sheriff of Monongalia County was read in which he requested help with sanity hearings and medical care for jail inmates. The matter was referred to the Public Health and Legislative Committee.

Dr. N. W. B. Craythorne was elected to courtesy associate membership in the Society. George A. Curry, M. D., Secretary.

* * * *

OHIO

Drs. W. P. Sammons and E. Lloyd Jones, both of Wheeling, were unanimously elected to honorary life membership in the Ohio County Medical Society during the regular monthly meeting held at the Wheeling Elks Club in October.

Dr. Charles H. Hiles of Wheeling, the new president, presided at the business meeting. He succeeds Dr. William J. Steger, also of Wheeling.

Drs. Harry S. Weeks, Jr., Daniel W. Dickinson and Robert M. Sonneborn, all of Wheeling, were elected to the Society's Board of Censors and Grievance Committee.—William H. Hagedorn, Jr., Executive Secretary.

Legislation Against Side Effects?

The unexpected appearance of side effects in drug therapy has been and will be due not to inadequacy of laws but to the inadequacy of scientific knowledge.

Protection against side effects cannot be legislated. There will always be instances where a drug will be prescribed, despite its side effects, because the alternative is worse. Every drug is to some extent toxic. Even the purest tap water can be harmful under certain conditions.

A doctor must always weigh the disadvantages of a drug against the expected advantages. The best and most extensive legislation in the world will not help him in this decision. But restrictive legislation can tie his hands.

The problem, I repeat, is not lack of legislation but lack of exact scientific knowledge.—Austin Smith, M. D., President, Pharmaceutical Manufacturers Association.

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President Elect: Mrs. Pat A. Tuckwiller, Charleston
First Vice President: Mrs. L. Dale Simmons, Clarksburg
Second Vice President: Mrs. A. J. Villani, Welch
Third Vice President: Mrs. Andrew J. Weaver, Clarksburg
Fourth Vice President: Mrs. W. V. Wilkerson, Whitesville
Treasurer: Mrs. Grover C. Hedrick, Jr., Beckley
Recording Secretary: Mrs. J. A. B. Holt, Charleston
Corresponding Secretary: Mrs. C. J. Holley, Wheeling
Parliamentarian: Mrs. J. E. Sparco, Jr., Wheeling

FALL CONFERENCE IN WHEELING

Thirty-five members attended the 1962 Fall Conference and Board of Directors Meeting of the Woman's Auxiliary to the West Virginia State Medical Association, which was held at Oglebay Park in Wheeling, October 10-11.

Mrs. Howard G. Weiler of Wheeling, President of the State Auxiliary, presided at the business sessions.

Mrs. Pat A. Tuckwiller of Charleston, President Elect of the State Auxiliary, presented a report on the Fall Conference of the AMA Auxiliary held in Chicago, and Mrs. Lynwood D. Zinn of Clarksburg, Chairman of the Rural Health Committee, discussed the 15th Annual Rural Health Conference at the WVU Medical Center in Morgantown on October 4.

Mrs. Weiler was hostess at an Informal Hour before dinner on Wednesday evening, October 10, and the Board members were guests of the Woman's Auxiliary to the Ohio County Medical Society at a continental breakfast held on Thursday morning—Mrs. Francis J. Gaydosh, State Publicity Chairman.

* * * *

GREENBRIER VALLEY

The Woman's Auxiliary to the Greenbrier Valley Medical Society held its regular monthly meeting at the home of Dr. and Mrs. Don F. Shreve in White Sulphur Springs on October 16.

Mrs. Ann Blair Alderson of Lewisburg delivered an address on "Mental Health."

Mrs. Stuart T. Bray of White Sulphur Springs, the president, presided at the business meeting. Mrs. Bray, and Mesdames E. L. Crumpacker, James P. Baker, Eugene J. Morhous and Harvey A. Martin assisted the hostess.

* * * *

HARRISON

Dr. William R. Hunt of McKeesport, Pennsylvania, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society at the Stonewall Jackson Hotel in Clarksburg on November 1.

Doctor Hunt, a member of the Speaker's Bureau of the American Medical Association, scored the Kennedy Administration's King-Anderson type legislation which

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would place medical care for the aged under Social Security.

"As proposed, it is a fraud on the aged, who will be greatly disappointed to find that if the program becomes law, the provisions will be meager and not at all the answer to their medical-hospital problems," he said. Doctor Hunt said the present Kerr-Mills legislation would, if properly implemented, provide adequate medical care for the aged.

Mrs. Joseph Gilman of Clarksburg, chairman of the Auxiliary's Legislative Committee, served as program chairman and introduced Doctor Hunt. Mrs. Charles S. Harrison of Clarksburg, the president, presided at the meeting attended by more than 80 persons.—Mrs. J. Keith Pickens, Chairman, Press and Publicity.

* * * *

MARION

Mr. John W. Pompelli of Chicago, Field Representative of the American Medical Association, spoke at a joint meeting of the Marion County Medical Society and Woman's Auxiliary held at the Fairmont Hotel in Fairmont on October 30.

He stated that the proposed King-Anderson type legislation which would place medical care for the aged under Social Security, is a "cruel hoax" upon the nation's senior citizens. He said that the Kerr-Mills legislation now in effect in West Virginia provides greater assistance to the aged than the Social Security approach.

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Mr. Pompelli, who has been reassigned by the AMA to the West Coast, introduced his successor, Mr. Harry R. Hinton, also of Chicago.

Mrs. Paul S. Gotses of Fairmont, president of the Auxiliary, presided at the meeting. Mrs. Seigle W. Parks of Fairmont introduced Mr. Pompelli and Mrs. G. Thomas Evans of Fairmont, the vice president, was in charge of arrangements.

* * * *

MERCER

Dr. Frank J. Holroyd of Princeton was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Mercer County Medical Society held at the Elks Country Club in Princeton on October 15.

Doctor Holroyd, who is an AMA Delegate from West Virginia, discussed "State Medical Legislation." A question and answer period followed his presentation.

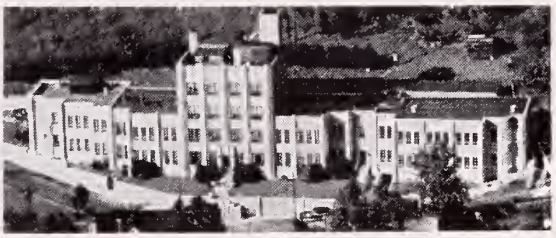
Mrs. Frederic C. Goodall of Princeton, the president, presided at the meeting which was attended by twenty-five members.

* * * *

MINGO

The regular monthly meeting of the Woman's Auxiliary to the Mingo County Medical Society was held at the home of Dr. and Mrs. J. C. Lawson in Williamson on October 25.

Mrs. Frank J. Burian of Williamson, the president, presided at the business meeting. Fund raising projects to provide money for the establishment of a school for retarded children were discussed.



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The Auxiliary also approved the purchase of "Children Limited" magazine for distribution to physicians and hospitals in the Mingo County area.—Mrs. Don V. Hatton, Secretary.

* * * *

MONONGALIA

The Woman's Auxiliary to the Monongalia County Medical Society celebrated the 13th anniversary of its founding with a luncheon at Lakeview Country Club in Morgantown on October 2.

Mrs. Harold G. Young, the president, presided during the business meeting at which time plans and projects for the coming year were discussed.—Mrs. Walter H. Moran, Jr., Corresponding Secretary.

* * * *

OHIO

A panel discussion on "Auxiliary Views and News" was held at the regular monthly meeting of the Woman's Auxiliary to the Ohio County Medical Society at the Wheeling Country Club on October 23.

Members of the panel were Mrs. Howard G. Weiler, president of the Woman's Auxiliary to the West Virginia State Medical Association, Mrs. D. E. Greeneltch and Mrs. James E. Spargo, Jr., all of Wheeling.

Mrs. George R. Clarke of Wheeling was hostess for the luncheon meeting. She was assisted by Mesdames Robert O. Strauch, David W. Palmer, A. J. Barger, R. Alan Fawcett, Chesterfield J. Holley and Francis J. Gaydosh, all of Wheeling.

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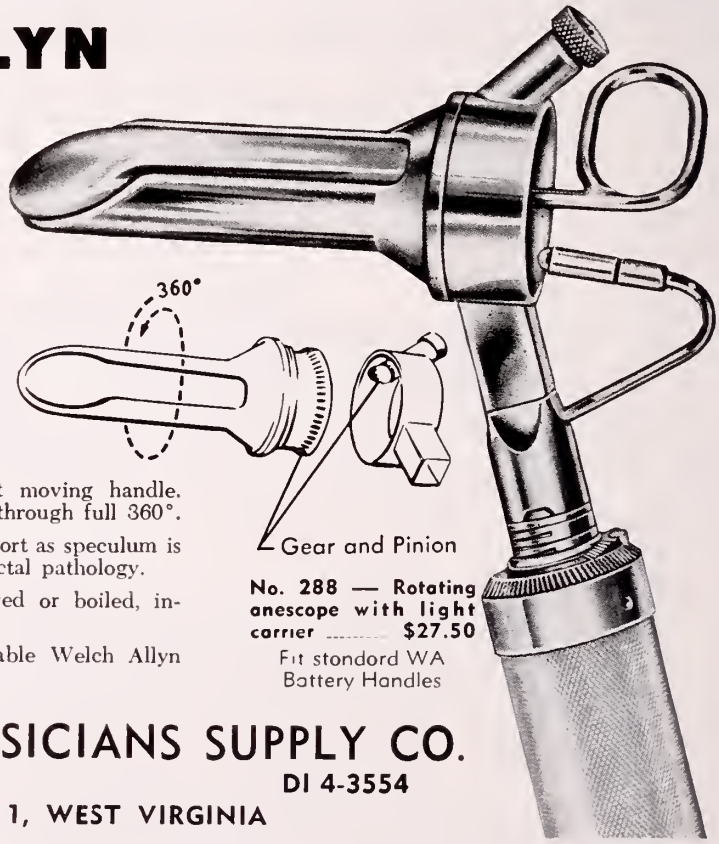

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PARKERSBURG ACADEMY

The first fall meeting of the Woman's Auxiliary to the Parkersburg Academy of Medicine was held in October at the home of Dr. and Mrs. John C. Bryce in Parkersburg.

Assisting Mrs. Bryce were Mesdames Edward B. Holmes, David B. Thornburgh, Ira Connolly, Jr., Lawrence R. Leeson, Alfonso Morales and Harold W. Ulch, all of Parkersburg.

Mrs. Leeson, the president, presided at the business meeting.—Mrs. Richard J. Lilly, Correspondent.

Freedom in the Field of Health Care

Those who advocate more inroads upon our liberty fail to recognize that it is not a mere coincidence that the life span of Americans today is longer than that of the people of any other major nation. It is no accident that there are more than 3,000,000 Americans alive today who would be dead if our national death rate had not been reduced through improved diagnosis and care. These facts are not due to climate, to food, or to public health measures. They are due to the dynamism, the spirit, and the freedom of choice existing today within the field of health care.

The three fundamental elements of medicine in this country—the physician, the pharmacist, and the pharmaceutical manufacturer—have worked together in a climate invigorated by the spirit of freedom, and together they have provided medical care unsurpassed anywhere in the world.—Francis C. Brown, President, Schering Corporation.

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Neurological Surgery:
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Albert M. Valentine, M. D.
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Book Reviews

SURGERY IN WORLD WAR II—Volume I. Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army; Editor-in-Chief, John Boyd Coates, Jr., M. D. Medical Department of the United States Army.

This volume was prepared and published under the direction of Lt. Gen. Leonard D. Heaton, and the editor-in-chief was John Boyd Coates, Jr., M. D.

It is said, and rightly so, that medical histories of wars are rarely read, even in time of war. This volume, one of the total series that tells the story of the United States Army Medical Department in World War II, is the first of two books devoted to the activities of the Surgical Consultants. The second volume will appear shortly.

The chapters in this volume dealing with the work of Army Consultants deserves the most careful reading, and the summary of the story of the blood program in World War II is most revealing.

The physician who served as Chief Surgical Consultant to the Surgeon General of the Army was the late Brig. Gen. Fred W. Rankin, a most remarkable choice. His personal performance in the office of the Surgeon General brought about the great success of the Surgical Consultant system. The contents of the volume comprises the Surgical Consultants, their activities in the zone of the Interior, Surgical Consultants in the service commands, and Surgical Consultants to field armies in the theaters of operation. Contained also are 104 remarkable illustrations.

There is a chapter of special interest to many by Colonel Snyder in regard to his visits to a number of German hospitals in May, 1945, and his discussions with the German surgeons in the use of the "Kuntscher Nail."

To read this material will cause you to appreciate the enormous value of the Medical Department of the United States Army.—C. Frederick Fisher, M. D.

* * * *

WOUND BALLISTICS—Medical Department of the United States Army. Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army; Editor-in-Chief, Col. James Boyd Coates, Jr., (MC); and Editor for Wound Ballistics, Maj. James C. Beyer, (MC).

This volume was prepared and published under the direction of Lt. Gen. Leonard D. Heaton, Surgeon General of the United States Army. The Editor-in-Chief was Col. James Boyd Coates and the Editor for Wound Ballistics was Maj. James C. Beyer.

This volume, consisting of 850 pages, 364 illustrations, 12 chapters and 9 appendixes, represents an unbelievable mass of comprehensive, detailed information. Enemy ordnance is reviewed from booby traps on up.

Discussing causative agents of battle casualties in World War II, the figures differed according to the Theatre of Operation. Smaller arms caused between 14 and 31 per cent of the total casualties: the Mediterranean Theater 14.0 per cent, the European Theatre 23.4 per cent, and the Pacific Theatre 30.7 per cent.

Artillery and mortar fire together were responsible for 65 per cent of total casualties in the European and Mediterranean Theatres, 64.0 per cent and 69.1 per cent, respectively. In the Pacific Theatre these casualties accounted for 47.0 per cent. The mechanism of wounding, yaw and spinning especially, is most interesting and in fine detail.

Protective armor is discussed in the casualty survey of the New Guinea and Burma campaigns, and the discussion on the Bougainville Campaign in Chapter V deserves close reading.

Chapter VI presents an examination of 1,000 American casualties killed in Italy and is complete with purpose and methods of study, statistical studies and case reports. The great number of us associated with the Fifth Army will be interested in Chapter VII, a study of the Fifth Army Hospital battle casualty deaths. Chapter VIII presents a casualty survey of Cassino, Italy. Chapter XI discusses protective armor beginning with the development of the helmet. Body armor, eye armor, special body armor, and finally the mobile shields are discussed.

The Medical Corps is greatly interested in any item that reduces morbidity and mortality in battle field casualties. This offers a hope that peacetime stagnation will not shackle the developmental program, and that armor will be available at once in the event of future hostilities.

This is a work that should be read carefully and slowly. The information contained is lucidly presented and denotes even to the casual reader an enormous effort by many. Even the Metropolitan Museum of Art in New York City was consulted in an effort to improve the protective coverage and ballistic limit of the helmet. The photographs also will recall much to all of us.

This volume merits the highest praise and is a reflection again upon the great resources of the Surgeon General of the United States Army and his editorial staff.—C. Frederick Fisher, M. D.

New Saunders Books

W. B. Saunders Company features the following recent books in their full-page advertisement appearing on page vii in this issue:

Warren—"Surgery." A valuable new volume emphasizing today's principles of surgical disease rather than mere mechanical techniques.

Schmeisser—"A Clinical Manual of Othhopedic Traction Techniques." Clearly describes and illustrates the application and advantages of traction in the management of common fractures.

Wechsler—"Clinical Neurology." Helpful information on the diagnosis and management of virtually every clinical neurologic problem you'll meet in daily practice.

And even these were the fortunate ones, despite the fact that they were to carry a disfigurement for life. Many died. Particularly if meningitis had set in before surgery...

You see very few mastoid scars around today – and, under 20 years of age, they are almost nonexistent.

But, not so many years ago (1934) it was a different story:

*"No case of acute mastoiditis should be accepted for insurance unless the ear has healed up after operation and has remained so for at least six months."**

From insurance risk to a practically unknown entity in medicine is quite a record for the relatively few intervening years between then and now. The reasons are not hard to come by. Diagnostic techniques have improved enormously, as has the quality of medical education. And, we submit, so has the quality of the medicines which have become available.

Yet, the value of independent drug research has been seriously challenged – research which has produced the chemotherapeutic compounds which make the *cure* of mastoiditis practically a routine, not even a worrisome, procedure. True, the cost may run as high as $15.00. Yet, ask the man who paid $1,000.00 for his mastoid scar which he would have preferred – if he had had the choice.

*Asherson, N., "Acute Otitis and Mastoiditis in General Practice," H. K. Lewis & Co., Ltd., London, 1934.

This message is brought to you on behalf of the producers of prescription products. A display card of this ad for your waiting room is available. Write:

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Correspondence

OFFICE FOR DEPENDENTS' MEDICAL CARE
OFFICE OF THE SURGEON GENERAL, U. S. ARMY
Washington 25, D. C.

Oct. 31, 1962

Mr. William H. Lively
Executive Secretary
West Virginia State Medical Association
Post Office Box 1031
Charleston, West Virginia

Dear Mr. Lively:

The retention of certain servicemen beyond their normal date of expiration of active duty tours has been directed by the Secretary of Defense. Implementation poses many problems. Among them is the valid identification of the extendees' dependents who will remain eligible for certain benefits while their sponsors remain on active duty.

The extension of tours of duty may result in some dependents being without a valid Identification Card for some time. The basis of identification of dependents is, as you know, the Uniformed Services Identification and Privilege Card (DD Form 1173). Each card carries an expiration date of eligibility. This date, in the case of dependents of non-career personnel, is the same as the expected expiration date of the sponsor's tour of active duty.

In the past, the "expiration date" on the ID Card has been the governing factor in determining that eligibility still exists. Since the involuntary extension of the tours of duty of many servicemen is effective almost immediately, the probability exists that some still-eligible dependent wives and children may apply for civilian medical care to which they are still entitled. They may not, however, have in their possession the required proof of their eligibility.

No change is contemplated in the provision of our contract which states that claims may not be processed for payment until the dependents have proven their eligibility to receive care. Service personnel will be advised that it is their responsibility to take necessary action to "update" the evidence of dependents eligibility.

It is most probable, however, that some dependents will be in need of authorized medical care from civilian sources prior to the time this action has been completed. In such cases, the dependent has been instructed to explain the situation to the physician and hospital authorities. They have been advised to present, if available, some tangible evidence such as allotment checks, official orders, directives, or personal letters which state the pertinent facts to the physician or hospital to help support the dependent's claim of continued eligibility.

This office is not empowered to broaden the "good faith" aspect of our contract. The number of dependents temporarily "unidentified" who require medical benefits will not be large.

In view of the situation at hand, I would appreciate your assistance in encouraging physicians and hospitals to exercise patience and understanding during the next several months when their services are requested by dependents of these extendees.

I must emphasize, however, that no claims may be processed for payment unless the dependent has provided a valid DD Form 1173 or a statement of eligibility as required by our contract.

This information is being furnished to all contractors and to the editors of leading medical and hospital journals. We would appreciate it if you could publish a copy of this letter, or an extract of the information in the next copy of your Medical Society journal or any other news media which is circulated to your membership.

Sincerely,

BRYAN C. T. FENTON
Colonel, MC, USA
Executive Director

Coverage Increases

At the end of 1961, 125.3 million Americans had both surgical expense and hospital insurance and another 9.7 million had hospital coverage through insurance companies, Blue Cross-Blue Shield and similar groups.

Insurance companies paid $623 million in surgical benefits alone in 1961, a 13 per cent increase over the $552 million paid out by these firms in 1960. The Health Insurance Institute said the number of persons covered by surgical insurance had increased by 4.3 million over the 121 million in 1960.

New Film on Cancer Detection

A new film, "Cancer Detection: Proctosigmoidoscopy in Office Practice," is available for showing before meetings of county medical societies. The film was prepared by Dr. Emerson Day, Director of Strang-Cancer Prevention Clinic in New York City, in cooperation with the C. B. Fleet Company.

The 15-minute 16mm color film illustrates the necessary equipment for routine proctosigmoidoscopy, home and office preparation of the patient for this procedure; and the examination itself, which includes inspection, palpation and proctosigmoidoscopy.

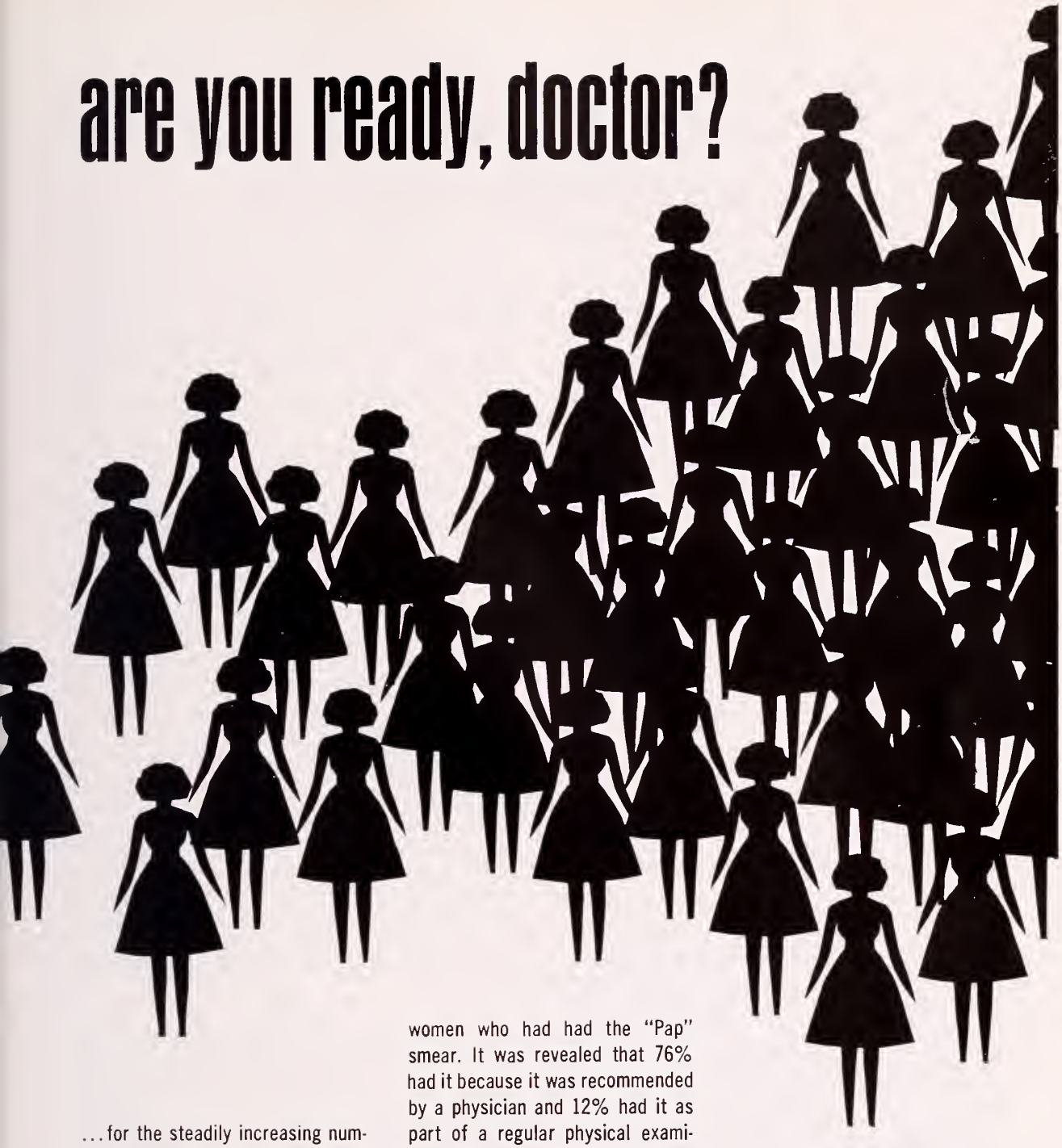
The film may be obtained by contacting the C. B. Fleet Company, Inc., 921-927 Commerce Street, Lynchburg, Virginia.

PG Course on Cardiology

A postgraduate course on 'Three Days of Cardiology" will be presented at the Grady Memorial Hospital in Atlanta, Georgia, March 27-29, 1963, under the sponsorship of the American Heart Association and the Emory University School of Medicine.

Registration fee for the three-day meeting is $30. Further information may be obtained by writing the Emory University School of Medicine, 69 Butler Street, SE, Atlanta 3, Georgia.

are you ready, doctor?



...for the steadily increasing number of women who want the "Pap" smear as part of their regular checkups? By 1961, the number who had this cytologic examination had climbed to an estimated 10,000,000!

While the educational program conducted by the American Cancer Society has succeeded in alerting women to the vital importance of the "Pap" smear, it is the physician who plays the key role. This was confirmed in a recent survey of women who had had the "Pap" smear. It was revealed that 76% had it because it was recommended by a physician and 12% had it as part of a regular physical examination. Thus a total of 88% had it because of physicians' actions.

As the number of uterine cytological examinations rises, the death rate from uterine cancer declines. Many authorities estimate that most deaths from this disease could be eliminated if these examinations were routinely performed. More and more women are ready for it and are willing to budget time and money for it. Are you ready for them, doctor?

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Quality of diabetic control & Quantitation of urine-sugar

In the diagnosis of diabetes, the urine-sugar test may be little more than a screening adjuvant. But in the everyday management of diabetes, the urine-sugar test is the most practical guide we have.[1] Routine testing, however, should not only detect, but also determine the **quantity** of urine-sugar. Quantitative testing is essential for satisfactory adjustment of diet, exercise and medication. Furthermore, day-to-day control of diabetes is in the patient's hands. Quality of control is thus best assured by the urine-sugar test which permits the most accurate quantitation practicable **by the patient.**

CLINITEST® permits a high degree of practical accuracy and is very convenient.[2] Its clinically standardized sensitivity avoids trace reactions, and a standardized color chart minimizes error or indecision in reading results. CLINITEST distinguishes clearly the critical ¼%, ½%, ¾%, 1% and 2% urine-sugars. It is the only simple test that can show if the urine-sugar is over 2%.[3] Your nurse or technician will appreciate these advantages; your patient on oral hypoglycemic therapy will find them helpful. Furthermore, CLINITEST may be a vital adjunct in the management of the diabetic child or the adult with severe diabetes.

(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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DECEMBER 1962

when urinary tract infections present a therapeutic challenge...

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Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections, such as colds, influenza, or viral infections of the throat, or as a prophylactic agent. *Precautions:* It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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